WASHINGTON STATE RESPONDS

PROVIDING EDUCATIONAL INFORMATION ON HIV/AIDS & OTHER INFECTIOUS DISEASES AND REPRODUCTIVE HEALTH

FEBRUARY 2006

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The Washington State Department of Health HIV Prevention & Education Services, Client Services, and the Governor's Advisory Council on HIV/AIDS (GACHA) share a web address. Go to **www.doh.wa.gov/hiv.htm** for program access. You can also access the HIV Prevention & Education Services website at the old web address: **www.doh.wa.gov/cfh/hiv_aids/prev_edu/**.

Washington State Responds Quarterly Newsletter Now Electronically Distributed

Now that WSR is distributed electronically on our web site, we can send you an e-mail notification when the new issue is available online. In order to receive this notice please send your e-mail address with the subject title: **WSR E-List**. All you need to include in your note is your complete e-mail address. Please send to: **barbara.schuler@doh.wa.gov**.

HIV/AIDS Trainings to Meet State Licensing Requirements

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Anacortes (Skagit County)	(360) 299-1342 Jo Ann Hoover	4 hour 7 hour Video Courses	No charge	Offered by Island Hospital. For residents of Island, Skagit and San Juan Counties only.
Bellingham (Whatcom Co.)	(360) 733-3290	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $40 for 4 hour $60 for 7 hour	Offered by the Whatcom County-Bellingham American Red Cross.
Bellingham (Whatcom Co.)	(360) 715-8350	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 7 hour	Offered quarterly through Bellingham Technical College.
Bellingham (Whatcom Co.)	(360) 715-8350	4 hour Infectious Disease Prevention for EMS	$30 for 4 hour	Offered quarterly through Bellingham Technical College.
Bremerton (Kitsap County)	(360) 377-7307	4 hour 7 hour	$25 for 4 hour $30 for 7 hour	Offered by Kitsap Home Care Services Training Center.
Bremerton (Kitsap County)	(360) 475-7359	2.5 hour	$15 for 2.5 hour	Offered by Olympic College in Bremerton.
Bremerton (Kitsap County)	(360) 377-3761	2.5 hour 4 hour 7 hour	$21 for 2.5 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Bremerton (Kitsap and Pierce Counties)	(360) 405-0430 (253) 474-5879	2 hour 4 hour	$15 for 2 hour $15 for 4 hour	Offered by instructor Francis Hall. Also available in Pierce County.
Clallam County (Port Angeles)	(360) 417-2352 K. McDaniel	2 hour	$10 for 2 hour	Offered by Clallam County Health Department.
Clark County (Vancouver)	(360) 693-5821	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $50 for 7 hour	Offered by the American Red Cross.
Clark County (Vancouver)	(360) 759-4404 **http://www.nwrtc.org**	7 hour 4 hour	$60 for 7 hour $50 for 4 hour	Northwest Regional Training Center.
Colville (Ferry, Stevens and Pend Oreille Counties)	1-800-827-3218 Angie	2 hour	No cost for 2 hour classes	Offered by Northeast Tri-County Health District.
Coupeville (Island County)	(360) 678-5151	4 hour 7 hour	Call for info	Offered by Island County Health Department and Whidbey General Hospital.
Edmonds (Snohomish County)	(425) 640-1840	7 hour	$89 for 7 hour Also receive one credit.	Offered by Edmonds Community College.
Everett (Snohomish County)	(425) –259-9899 Anne Miles; Ext. 16 **http:// www.pwnetwork.org/**	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 5 hour	Offered by Positive Women's Network.
Everett (Snohomish County)	(425) 252-4103 Laura; Ext.12	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $30 for 4 hour $60 for 7 hour	Offered by the American Red Cross. Scholarships are available.

HIV/AIDS TRAININGS TO MEET STATE LICENSING REQUIREMENTS, CONTINUED

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Grays Harbor	(360) 533-3431	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Grays Harbor and Pacific County	(360) 267-3404 (360) 267-3405	2 hour 4 hour 7 hour 10 hour	$30 for 2 hour $45 for 4 hour $75 for 7 hour $85 for 10 hour	Offered by Critical Incident Stress Management (CISM). They also offer First Aid/CPR classes.
Kirkland (King County)	(425) 739-8104 (425) 739-8112	7 hour	$69 for 7 hour	Offered by Lake Washington Technical College.
Mason County	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Mt. Vernon (Skagit County)	(360) 428-2151	4 hour 7 hour Videos	$25 handling fee for video tapes	Offered by Skagit Valley Hospital.
Mt. Vernon (Skagit County)	(360) 424-5291	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $35 for 4 hour $45 for 7 hour	Offered by American Red Cross.
Okanogan	(509) 422-7153	2 hour 4 hour 7 hour	$30 for 2 hour $30 for 4 hour $30 for 7 hour	Offered by Okanogan Health District.
Olympia (Thurston County)	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Olympia	(360) 352-2375	4 hour 7 hour	$30 for 4 hour $60 for 7 hour	Offered by United Communities AIDS Network (UCAN).
Puyallup (Pierce County)	(253) 841-3311	2 hour 4 hour 7 hour	$15 for 2 hour $40 for 4 hour $50 for 7+ hour	Offered by H.E.L.P. (HIV/AIDS Educational Learning Place) the C.P.R. First Aid Company.
San Juan County	(360) 378-4474	2 hour 4 hour 7 hour	$20 for 2 hour $20 for 4 hour $20 for 7 hour	Offered by San Juan County Health & Community Services.
Seattle/King Co. & South Snohomish Co.	(206) 784-5655 www.healthinfonetwork.org	2 hour 4 hour 7 hour	$10 for 2 hour $25 for 4 hour $40 for 7 hour	Offered by Health Information Network. They will also travel to your facility.
Seattle	800-783-2437	2.5 hour 4 hour 7 hour	$36 for 2.5 hour $44 for 4 hour $58 for 7 hour	Offered by Health Impact. Audio course available.
Seattle	(206) 726-3534	2 hour 4 hour 7 hour	$21 for 2 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Seattle	(206) 850-2070 Betty Morgon aarthministry@yahoo.com	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $45 for 4 hour $60 for 7 hour	African Americans Reach and Teach Ministries (AARTH)
Spokane	(509) 326-3330 Ext. 210	2 hour 4 hour	$20 for 2 hour $30 for 4 hour	Offered by the American Red Cross.
Spokane	(509) 324-1542	7 hour	$50 for 7 hour	Offered by the Spokane Regional Health District.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Spokane	(509) 928-1588 Ext. 16	7 hour	$45 for 7 hour	Offered by Visions Community Resources.
Spokane	(509) 236-2430 Becky Nauditt	2 hour 4 hour	$18.00 $30.00	Offered by Becky Nauditt
Tacoma (Pierce County)	(253) 841-3311 Barbara Miller	2 hour 4 hour 7 hour	$30 for 2 hour $40 for 4 hour $50 for 7 hour	Offered by C.P.R. Company.
Tacoma (Pierce County)	(253) 474-0600	2 hour 4 hour 7 hour	$15 for 2 hour $43 for 4 hour $55 for 7 hour	Offered by the American Red Cross.
Tacoma (Pierce County)	(253) 566-5020	4 hour video course 7 hour video course	$49 for 4 or 7 hour video course	Offered by Tacoma Community College.
Vancouver	(360) 992-2939 Press Option One	2 hour 4 hour 7 hour	$30 for 2 hour $50 for 4 hour $60 for 7 hour	Offered by Clark College Continuing Education Program. Take home program that offers discounts for 2 or more students.
Walla Walla	(509) 527-4330	7 hour	$45 for 7 hour	Offered quarterly by Walla Walla Community College.
Whitman County (Colfax)	(509) 397-6280	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
Whitman County (Pullman)	(509) 332-6752	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
White Salmon (Klickitat County)	(509) 493-1101	2 hour, 4 hour, 7 hour and other First Aid classes	$25 for 2 hour $30 for 4 hour $50 for 7 hour	Offered by Skyline Hospital.
Yakima	(509) 248-3628	7 hour	$50 for 7 hour	Offered by Planned Parenthood of Central Washington.
Yakima	(509) 457-1690	2 hour	$20 for 2 hour	Offered by the American Red Cross.
Yakima	(509) 853-2034 or 1-877-620-6202 http://www.fas-training.biz/	4 hour 7 hour and other First Aid classes	$40 for 4 hour $55 for 7 hour	Offered by First Aids & Safety Training.

HIV/AIDS TRAININGS TO MEET STATE LICENSING REQUIREMENTS, STATEWIDE

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Statewide	(206) 784-5655 http:// www.healthinfonetwork.org/	HIV/AIDS 7-hour Video Course	$250	Offered by Health Information Network. Designed to assist health care facilities meet Washington State Licensing requirements.
Statewide	(206) 784-5655 http:// www.healthinfonetwork.org/	HIV/AIDS Internet Online 4/7 hour Video Course	$250	Offered by Health Information Network and Seattle Community College TV Division. Designed to assist health care facilities meet Washington State Licensing requirements.
Statewide	(206) 543-1047	HIV/AIDS Training Course on DVD	$95 for 7 hour	Offered by U of W School of Nursing. Designed to assist health care facilities to meet WA State requirements.
Statewide	(425) 564-2012 www.bcc.ctc.edu	HIV/AIDS Self Study Program	$60 for 4 hour* $80 for 7 hour* *refundable deposit of $100 includes mailing	Offered by Bellevue Com. College Continuing Nursing Education and Health Information Network.
Statewide Internet Classes	(707) 937-0518 www.nursingceu.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Washington State HIV/AIDS internet course offered by Wild Iris Medical Education.
Statewide Internet Classes	1-800-346-4915 www.classesonline4u.com	2 hour 4 hour 7 hour	$20 for 2 hour (Also in Spanish) $40 for 4 hour $70 for 7 hour	Online course offered by Prevention MD.
Statewide Internet Classes	(509) 628-1317 Kathleen Hayes www.designerwebsitesolutions.com	4 hour 2 hour	$40 for 4 hour $20 for 2 hour	Online course offered by Designer Website Solutions.

HIV Prevention Counseling and Testing Training Schedule for 2006

These one-, two- and three-day courses will assist health care providers and others develop necessary skills for providing pre- and post-test counseling for HIV testing, as required by Washington State law.

These courses are not intended for the general public.

Region	Trainer	Course Dates	
One (Spokane)	**Christopher Zilar** (509) 324-1542 Receptionist The cost varies according to length of class.	June 6-8 July 12-13	(3 day) (2-day)
Two (Yakima)	**Deborah Severtson-Coffin** (509) 454-3322 The cost for the 2-day class is $85.	February 23-24 April 27-28 June 29-30 June 21-23	(2 day) (2 day) (2 day) (3 day)
Three (Everett)	**Jordan Bower** **David Bayless** (425) 339-5275	March 20-22 June 26-28	(3 day) (3 day)
Four (Seattle)	**Kathy Silverman** and **Bill De Young** (206) 296-4649 or e-mail to: diane.ferrero@metrokc.gov The cost for the 2-day class is $125. The cost fot the 3-day class is $175.	March 7-9 May 16-18	(3 day) (3 day)
Five (Tacoma)	**Kim Ingram** and **Moni Muraki** (253) 798-2939 The cost varies according to length of class.	April 26-28 June 21-23 July 26-28	(3-day) (3 day) (3 day)
Six (Vancouver)	**Beth McGinnis** (360) 397-8111	March 8-10 July 12-14	(3 day) (3 day)

Calendar

FEBRUARY 6, 2006

Tribal Clinicians' STD Update is offered in Seattle on February 6th, 7th and 8th, with all training and travel expenses for clinicians serving tribal clinics in Oregon, Washington or Idaho reimbursed by **Project Red Talon.** Continuing Medical Education credits will be provided.

FEBRUARY 6, 2006

The **STD Update and Intensive course** provides participants with training in the most recent advancements in epidemiology, diagnosis, and management of viral and bacterial STDs. This course is designed for health care providers who diagnose and treat patients with sexually transmitted diseases. Applicants with at least six months of STD exam experience have the option of a 2-day practicum at the Public Health - Seattle and King County STD Clinic at Harborview Medical Center after completing the didactic course. The 2-day practicum session plus the didactic training comprises the STD Intensive Course. The registration fee for the didactic **February 6-8, 2006** STD Update course is $200. The registration fee for both the February 6-8, 2006 didactic course plus the 2-day clinical practicum (STD Intensive course) is $300. Please contact Ronnie Staats at (206) 685-9848, or **rstaats@u.washington.edu** for more information.

FEBRUARY 7, 2006

National Black HIV/AIDS Awareness Day *(NBHAAD)* is held on February 7, 2006. The primary goal of NBHAAD is to motivate Black Americans at risk for HIV to get educated and tested, and to get stakeholders involved in prevention education programs, HIV testing, press conferences, community forums and other activities to raise awareness and support for HIV prevention among African Americans. According to the **Centers for Disease Control and Prevention** (CDC), HIV/AIDS was among the top 3 causes of death for African American men aged 25–54 years and among the top 4 causes of death for African American women aged 20–54 years in 2001. It was the number 1 cause of death for African American women aged 25–34 years. African Americans accounted for 16,165 (50%) of the 32,048 estimated new HIV/AIDS diagnoses in the United States.

FEBRUARY 11, 2006

Join OUTKITSAP for Mardigras NIGHTOUT with disc jockey Ka-Ron at the Eagles Lodge, 205 6th Street, downtown Bremerton (use entrance on upper level of club). NIGHTOUT events have been sustaining a large crowd with old friends and also many new faces. These events are gay, lesbian, bisexual and transgendered social events with a nice balance of the community. They start at 8 p.m. With a requested $5 donation to cover expenses. NIGHTOUT is normally scheduled for the second Saturday of the month. Contact **nightout@outkitsap.org** for more information.

FEBRUARY 23, 2006

Each year, **Q&A for Advocates National Institute** hosts anti-violence workers from across Washington State, the region and the U.S. This **3-day training institute** addresses intimate partner violence in lesbian, bisexual, transgendered and gay communities. After the training, attendees have access to **North West Network** (NW Network) staff for on-going techni-

cal assistance and consultation as they implement strategies and skills learned during the training. Each year attendees report that the institute is inspirational and educational and makes a lasting difference in their work with all survivors. This year the training will be held from February 23rd through February 25th in the Seattle Center neighborhood. Visit the website **www.nwnetwork.org** to register, and remember that space is limited.

FEBRUARY 27, 2006

The 2006 National Conference on African-Americans and AIDS is a forum on HIV/AIDS held February 27th and 28th in Philadelphia, Pennsylvania for health professionals who provide care for African-Americans. The goal of the conference is to update knowledge, skills, and attitudes of health providers who care for patients with HIV/AIDS. The objectives are to familiarize participants with the epidemiology of HIV in the United States, guidelines and cutting edge clinical modalities for the management of HIV, current research, social and psychiatric concerns of the HIV-infected patient, policy initiatives, and political issues which impact HIV-infected patients. To register for the 2006 National Conference on African-Americans and AIDS go to **www.minority-healthcare.com.**

MARCH 10, 2006

CABLE POSITIVE, the cable and telecommunications industry's national non-profit AIDS action organization, provides funding for AIDS organizations and cable outlets to work together in joint community outreach efforts, or to produce and distribute new, locally focused HIV/AIDS-related programs through the Tony Cox Community Fund. **Grants are available up to $5,000** for eligible 501 (c)(3) organizations, with special consideration given to AIDS service organizations (ASOs) and cable systems and producers partnering with ASOs. **The next deadline for grant submissions is March 10, 2006**. Contact: Thomas Henning at (212) 459-1606 or e-mail: **thenning@cablepositive.org.**

MARCH 11, 2006

United Communities AIDS Network (UCAN), with the support of the Health and Human Service Office on Women's Health, Region X, is offering a **day of presentations and workshops for women and girls** of all ages in an inclusive and supportive environment. This special day addresses the specific needs of women and girls, and will be held at the First United Methodist Church at 1224 Legion Way S.E., Olympia, WA. Contact UCAN at (360) 352-2375 for more information.

MARCH 28, 2006

2006 Reproductive Health Conference on March 29 through 31 in **Seattle, Washington** offers a workshop entitled: **Ask, Screen, Intervene: Incorporating HIV Prevention Into the Medical Care of Persons Living with HIV**. This training targets medical care providers of HIV-positive patients including those providing STI and family planning services. The focus of the workshop is to assist providers in **learning new techniques to incorporate important intervention methods to help their patient reduce risk behaviors even in the constrained care setting.** Registration deadline is March 8. Contact Center for Health Training at (206) 447-9538 or **www.centerforhealthtraining.org.**

MARCH 31, 2006

Applications for the HIV/AIDS Regional Resource Network (RRN) Capacity Building Awards must be postmarked by March 31, 2006 to be considered. These mini-grants are meant to build the capacity of small CBOs to provide HIV/AIDS services. The RRN project also offers technical assistance, with the goals of the project being: 1) Increase the

capacity and sustainablility of community-based non-profit organizations (CBOs) to provide quality HIV/AIDS prevention and treatment services to communities of color and 2) Facilitate the development of relationships to increase collaboration between CBOs with local, state and federal public health and private agencies. Please contact Nicole Ikebata at (206) 615-2506 or e-mail **nikebata@osophs.dhhs.gov**.

May 2, 2006

Anchorage, Alaska is hosting the May 2nd through May 6th **HIV/AIDS Conference for Native Americans**. There is no registration fee. Purposes of the conference are to: provide Native peoples with accurate HIV/AIDS research information and issues while honoring Native people's learning styles, establish networks, foster spiritual and cultural grounding, and motivate local and national leaders to protect and preserve Native communities. Target audience includes healthcare and service providers, HIV/AIDS researchers, tribal and spiritual leaders, traditional healers and native people living with HIV/AIDS. For more information, visit **http://www.embracingourtraditions.org/home.asp**.

July 24, 2006

The 2006 National Conference on Latinos and AIDS is taking place July 24th and 25th, 2006 in Miami Beach, Florida. The conference audience, goal, and objectives are: to update the knowledge, skills, and attitudes of health care providers who care for patients with HIV/AIDS. This activity is also designed for healthcare media, federal and state legislators, AIDS service organization officers, social workers, pharmacists, nurses, peer counselors, church leadership and corrections healthcare personnel. The objectives are to familiarize participants with the epidemiology of HIV in the United States, current guidelines and cutting edge clinical modalities for the management of HIV, current research encompassing drug abuse and its connection to the HIV epidemic, social and psychiatric concerns of the HIV-infected patient, policy initiatives, trends and political issues which impact all HIV-infected patients. **To register for the 2006 National Conference on Latinos and AIDS**, go onto the official National Conference on Latinos and AIDS website at **www.minority-healthcare.com.**

Support Groups

The local chapter of **PFLAG (Parents, Families and Friends of Lesbians and Gays)** meets at 2 p.m. on the second Sunday of each month at First United Methodist Church, 1224 Legion Way S.E., Olympia. PFLAG is a national non-profit organization with over 200,000 members and supporters and over 500 affiliates in the United States. This vast grassroots network is cultivated, resourced and serviced by the PFLAG national office, located in Washington, D.C., the national Board of Directors and 14 Regional Directors.

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The YWCA of Clark County recently started the **Strong Positive Women's Group**, which meets each Thursday from 10 a.m.-11:30 a.m. Refreshments will be offered and childcare and transportation assistance are available with sufficient notice. Please call Norah at (360) 906-9138 to sign up or get more information.
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8 Limbs Yoga Center offers free **Yoga Classes for HIV+ people** on Wednesdays from 2 p.m.-3 p.m. at 500 E. Pike Street, Seattle, WA. Call (206) 325-8221.

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HIV/AIDS Support Group is an ongoing emotional support group for anyone who is HIV positive or who has AIDS, and it meets Mondays from 6:00 p.m.- 7:30 p.m. Drop-ins are welcome to attend this group; drop-in by 6:00 p.m. at 303 17th Ave East, Seattle, WA. If you would like more information, please call the Dunshee House at (206) 322-2437.

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HIV Positive Support Group is a new emotional support group for anyone newly diagnosed HIV positive. The group is especially welcoming of and helpful to those who are newly sero-converted. The support group meets Wednesdays, 7:30 p.m.-9:00 p.m. Drop-ins are welcome to attend this group; drop-in by 7:30 p.m. at 303 17th Ave East, Seattle. If you would like more information, please call the Dunshee House at (206) 322-2437.

Volunteer Opportunities

Lifelong AIDS Alliance provides housing and home chores, food and nutrition services, insurance continuation, transportation, case management, and emergency financial assistance to people living with HIV/AIDS;. Community services include prevention education and national public policy advocacy. Please **visit www.llaa.org** for more information about **volunteer opportunities**.

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Volunteers are needed as one-on-one mentors, summer camp counselors and camp program staff. **Rise n' Shine's** service area includes children and teens affected by HIV and AIDS living in King, Pierce, Snohomish and other Puget Sound counties. Stable, compassionate and giving individuals are needed to volunteer with this special group of children. For a volunteer application and information, please contact Danica Smith at (206) 628-8949 ext. 210 or e-mail **Danica@risenshine.org**.

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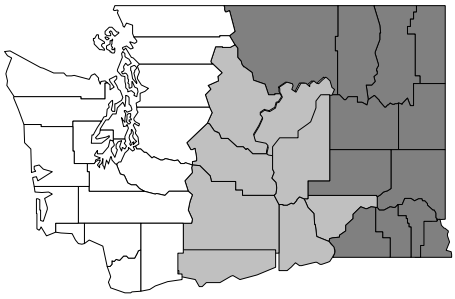
Shanti Volunteer Training takes place on February 25th and 26th, and March 4th and 5th, 2006. Volunteers provide one-on-one, nonjudgmental emotional support to people living with HIV/AIDS, cancer, MS, and other life-threatening illnesses. The Shanti training and volunteer experience has been described as life-changing for many volunteers. For more information, please call (206) 324-1520 ext. 3 or e-mail **shanti@multifaith.org.**

Regions 1 & 2



Region One (dark area) includes Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties. The Region One AIDSNET Office is in Spokane and the Coordinator is Barry Hilt at (509) 324-1551.

Region Two (gray area) includes Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima Counties. The Region Two AIDSNET office is in Yakima and the Coordinator is Wendy Doescher at (509) 249-6503.

Transitions

Madeline Sanchez left **Grant County Health District (GCHD**) in order to pursue her Bachelor's degree in education. She is enrolled in school full time, and appreciating all that comes with being a returning student. She was with Grant County for the past 5 ½ years in a fulltime position, and remains on staff with the Health District on an hourly basis for the outreach season and emergency response clinics, etc. She continues her involvement in HIV/AIDS through the State Planning Group and the Materials Review Panel.

Grant County Health District will continue to do outreach to detention centers as well as individual high risk groups in the community with the help of **Beth Stansfield, RN**, who joined GCHD this summer. Beth comes with a background of STD education and treatment via Family Planning in Okanogan County and has become an important part of the HIV/AIDS prevention team in Grant County.

The Grant County Community Partners in HIV Prevention Efforts (CPHPE) is looking forward to its second year working together to bring education, treatment, and awareness of HIV/AIDS, Hepatitis, and STDs to the people of Grant County. In its first year, many of the county's community based organizations, community health centers, and educational facilities collaborated on various projects to bring education and/or awareness to high risk communities.

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The Spokane Regional Health District (SRHD) HIV/AIDS and Adolescent Health Program welcomes new hires **Celeste Kuntz** and **Lisa Hinton** into the Adolescent Health Program. Additionally, the office welcomes **Jeanne Miffitt** who is sharing office space in the HIV/AIDS Program office. Jeanne works with New Horizon Health Care and provides Chemical Dependency Counseling to persons affected by HIV/AIDS or Hepatitis C in the HIV/AIDS and Hepatitis C Alcohol and Drug Program (HASAP).

The HIV/AIDS Program at SRHD has moved from the division of Health Promotion to the division of Epidemiology. The Adolescent Health Program remains with Health Promotion.

Also at **SRHD, Lynn Everson** coordinator of the SRHD Outreach Center and Needle Exchange, is facilitating **ANEW,** a weekly support group for women leaving prostitution. The group focuses on building strengths and survival skills. The group is meeting every Friday, 11 a.m., at the Outreach Center.
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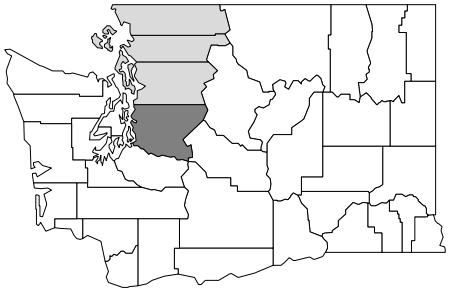
REGIONS 3 & 4



Region 3 (gray area) includes Island, San Juan, Skagit, Snohomish and Whatcom Counties. The Region 3 AIDSNET office is in Everett and the Coordinator is Alex Whitehouse at (425) 339-5211.

Region 4 (dark area) is King County. The Region 4 AIDSNET office is in Seattle and the Coordinator is Karen Hartfield, who can be reached at (206) 296-4649.

TRANSITIONS

Evergreen AIDS Foundation (EAF) in Bellingham, Washington, said farewell to **Michelle Dever.** She started as an intern in 1997 with a personal commitment to work in the HIV/AIDS field. A new job opportunity requires her to move out of the area; she will continue her prevention and education work in her new community.

ANNOUNCEMENTS

Public Health- Seattle and King County (PHSKC) began the CDC-sponsored **Antiretroviral Drug Resistance Testing** (ARVDRT) project in July 2003 to assess the prevalence of primary drug resistance and non-B subtypes among newly diagnosed HIV-infected people. ARVDRT initially ran at most sites submitting HIV tests to the Public Health laboratory in King County. The study was later expanded to include another large local laboratory and additional clinical sites in the Seattle metropolitan area. As of December 2005, 615 EIA+ specimens had been screened for eligibility, and 336 (55%) were found eligible (Table 1). Complete genotyping results were available for 283 (84%) of the specimen. Approximately 12% of newly diagnosed patients tested in the Seattle ARVDRT project had high level drug resistance, including 9 (3%) with multi-class resistance. A total of 22 (8%) were found to be non-B subtype, including 18 from foreign-born patients. About 10% of specimens did not have results due to small volume of specimen or difficulty with amplification of specimen during genotyping. For more information, please call the ARVDRT project line, (206) 205-1470.

Table 1. Results of genotyping from the Antiretroviral Drug Resistance Testing (ARVDRT) project (2003-2005), Seattle, Washington.

	N=283	%
Any high level resistance	33	12
protease inhibitor (PI)	6	2
nucleoside reverse transcriptase inhibitor (NRTI)	11	4
non-nucleoside reverse transcriptase inhibitor	27	10
Multi-class resistance	9	3
Non-B subtype	22	8

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Health Information Network continues to provide the HIV/AIDS licensing course for health care and child care providers. There are three options available for health care providers: 1) live classroom training for individuals; 2) on-line training for individuals; and 3) the 2004 HIV/AIDS video kit for institutions, schools, and facilities. Information about training options can be accessed through the web site at www.healthinfonetwork.org; click on "Training Options," and follow the links as needed.

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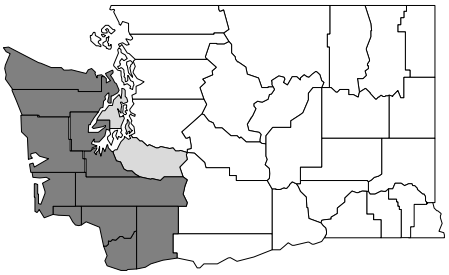
The new **"Who Does What"** is now available from the **HIV/AIDS Program, Public Health - Seattle & King County.** With a revised date of September 2004 and thoroughly updated in a brilliant yellow, this handy resource list includes more than 100 agencies and services in the Seattle/King County area. To place an order, simply call the HIV/STD Hotline at (206) 205-7837 or 1-800-678-1595 between the hours of 9 a.m. and 4 p.m., Monday through Friday.

Regions 5 & 6



Region 5 (gray area) includes Kitsap and Pierce Counties. The Region 5 AIDSNET office is in Tacoma and the Coordinator is Mary Saffold at (253) 798-4791.

Region 6 (dark area) includes Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties. The Region 6 AIDSNET office is in Vancouver and the coordinator is David Heal at (360) 397-8086.

Transitions

Clallam County Health Department welcomes their new HIV Public Health Nurse, **Beverly Simmons.** Beverly is new to HIV, so welcome aboard!

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Cowlitz County Health Department welcomes **Laura Tafoya,** the new Syringe Exchange worker. She has a background in Mental Health Services and is a great new addition to the team.

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Lewis County Health Department welcomes new IDU outreach worker **Kat Jensen.** Kat has been involved at Thurston County's healthmobile and is now coming on board as a group facilitator for an IDU intervention at Lewis County Health Department.

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Thurston County Public Health and Social Services Department said goodbye to **Diana Johnson,** who resigned from her position in November to pursue other opportunities. She worked for 15 years as a Health Education and Outreach Specialist in Thurston County. She was passionate about her local HIV/AIDS work in the community, and about international public health. Best of luck in your new endeavors, Diana!

Announcements

The **Clark County Health Department has moved** into the recently completed Center for Community Health in early January. The new physical location is 1601 Fourth Plain Blvd., Vancouver, WA 98661; their mailing address remains the same. All public services offered by the Health Department will be located on the third floor. The department's main number has changed to (360) 397-8000. All other direct lines and extensions will remain the same.
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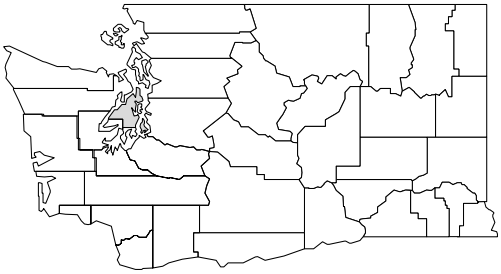
STATEWIDE NEWS



A new CDC-sponsored expanded surveillance project called the **Medical Monitoring Project (MMP)** started data collection in January 2006. MMP has a three stage random selection process starting with selection of states (Washington State was included among the 20 states selected), followed by medical providers, and then patients. A total of 24 providers are participating in Washington State (15 providers in King County and 9 providers outside of King County). Patients will be sampled from within those 24 provider offices. The purpose of MMP is to learn more about the needs and experiences of people who are receiving care for HIV. Data will be collected by chart review and patient interview. Chart review data include HIV-related treatments, diagnoses, and laboratory values. The interview asks patients about their health-care seeking and other behaviors impacting HIV care, such as adherence to HAART. For more information please call Elizabeth Barash (206) 296-2907 in King County, or Alexia Exarchos (253) 395-6730 at the Washington State Department of Health.

ANNOUNCEMENTS

STATE HIV/AIDS MATERIAL REVIEW PANEL

The HIV Prevention and Education Services Office is seeking viable candidates to serve on the State HIV/AIDS Material Review Panel. This panel is responsible for reviewing HIV/AIDS material produced or purchased with CDC funds. To ensure the panel maintains parity, inclusion and representation, interested person(s) are needed to review material that is intended to reach various races (*American/Indian/Alaskan Native, White, Asian, Native Hawaiian/Pacific Islander, African American/Black, more than one race)* ethnicities *(Hispanic or non-Hispanic),* risk populations *(HIV positive persons, Heterosexual, Injection drug users, transgender, men who have sex with men),* and different age groups. If you are interested, please contact Frank Hayes for additional information at: (360) 236-3486 or frank.hayes@doh.wa.gov.

STATE PLANNING GROUP

The State Planning Group (SPG) is scheduled to meet the 4th Thursday of the month from 9:00 A.M. to 2:30 P.M. in SeaTac, Washington. **For confirmation of dates and times, please check with Harla Eichenberger at (360) 236-3424** or visit: **http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/hiv_comm_plan.htm.**

COMMUNITY PLANNING

The six **AIDSNET Regions** continue to coordinate the local planning process through meetings of the Regional Planning Groups (RPGs). This process absolutely requires input and participation from members of the community infected and affected by this epidemic. Are you willing to become one of the voices that support effective prevention efforts? If so, please contact your local Regional Coordinator or DOH contact in the list below, for more information.

Barry Hilt - Region 1 AIDSNET (Spokane) – (509) 324-1551

Wendy Doescher – Region 2 AIDSNET (Yakima) – (509) 249-6503

Alex Whitehouse – Region 3 AIDSNET (Everett) – (425) 339-5211

Karen Hartfield – Region 4 AIDSNET (Seattle) – (206) 296-4649

Mary Saffold – Region 5 AIDSNET (Tacoma) – (253) 798-4791

David Heal – Region 6 AIDSNET (Vancouver) – (360) 397-8086

Brown McDonald – State Planning Group (SPG) – (360) 236-3421

HIV Prevention Focus

Adapting and Tailoring Interventions

Written By Frank E. Hayes; DOH, HIV Prevention and Education Services

INTRODUCTION

Reaching specific populations with interventions which have been evaluated and which have demonstrated effectiveness in changing risky behavior is not an easy task. There are a variety of interventions which have been scientifically proven to be effective in reducing risky behaviors in various populations. When conducting your search for an evidence-based/scientific based intervention which has been evaluated and shown to be effective in changing risky behavior, you should look for interventions which were originally conducted with your primary populations.

Additionally, you should extend your search to include interventions which may not have been originally conducted with your populations, but have been evaluated and proven to be effective in changing risky behavior. Do not eliminate any intervention until you have reviewed all possibilities. If an intervention was originally conducted with your specific population, that alone doesn't guarantee it will be effective with your population; nor does it mean an intervention originally conducted with another population will not be effective with your population. Changing certain characteristics of the original intervention is a feasible option.

DEFINITIONS

Prior to discussing adapting and tailoring interventions, I want to provide definitions that I feel are important for you to understand.

A*daptation* – Implies that the intervention is being delivered to a different population or in a different venue than the original study which demonstrated effectiveness. (Involves changing *who* receives a message and *where* it is delivered).

Adaptation must be addressed before attempting to tailor an intervention or service. The population and determinants that put a person at risk must be specified before messages and strategies can address those risks. Information about the risk behaviors and determinants can only be gathered through a formative evaluation of the primary population.

***Tailoring* –** Occurs when the intervention is changed to deliver a new message, at a new time, or in a different manner than originally described. (Changes *when* an intervention is delivered, *what* is addressed, and *how* the message is conveyed).

***Core elements* –** These are the components that are critical of an intervention's intent and design that are thought to be responsible for it effectiveness. These elements **must** be maintained without alteration to ensure the program is effective.

Key characteristics – These are crucial activities and delivery methods which are used in conducting an intervention. These items can be tailored or adapted to meet the needs of the agency and at risk-population. This will ensure the intervention will be culturally appropriate.

GETTING STARTED

The initial step you and your agency must complete is conducting a formative evaluation. A formative evaluation will furnish information that will guide the process development, adaptation, tailoring, and implementation for an intervention. During the formative evaluation, you will collect data that will describe the needs of the population and the determinants that place them at risk. The evaluation will also provide answers to: how the intervention should be designed or modified to address your populations' needs; what can be learned from pre-testing your approach; and whether the materials being considered for use are appropriate.

Population Formative Evaluation

Contact with and input from the population you intend to reach is imperative. This evaluation will provide valuable insight into your desired population. Contact community members (be sure to include community leaders and gatekeepers) and conduct a priority population needs assessment. This assessment will provide: cultural issues, community values, specific risk behaviors, influencing factors, and information as to what would be gender appropriate and ethnically appropriate. Once the initial contact has been accomplished, use the input you gathered to investigate the availability of an evidence/science based intervention which has been evaluated and shown to be effective. You may also develop an appropriate intervention based on a theory or model. Your priority population must be involved when you plan, implement, and evaluate the intervention.

Agency Formative Evaluation

It is also very important to conduct a formative evaluation on your agency. This will determine if your agency has delivery capacity (e.g., money, time, material, trained staff) to conduct and/or adapt and tailor any intervention. Agencies should discuss and evaluate their cultural competency. Your agency should review the 14 standards produced for the Office of Minority Health to gauge the cultural competency of your agency. The standards may be reviewed by visiting: **http://www.omhrc.gov/clas/ds.htm**

SELECTING AN INTERVENTION

When the formative evaluation has been completed, you are ready to move forward with the next five steps.

1. Conduct a comprehensive review of evaluated intervention packages and studies/journal articles describing interventions which have been effective in changing risky behaviors.
2. Select an intervention that fits your desired population rather than trying to change the population to fit into an intervention. Trying to change the population to fit into an intervention you have located would be a MAJOR error. Other important issues that you should ask yourself and address when selecting an intervention are:
    - How relevant is the intervention to my organization's mission and values?
    - Is it comparable with who we are and want to be as an organization?
    - Is this feasible for me to do with my space, personnel, time, financial resources, quality assurance guidelines, and other programmatic and administrative commitments?
    - Will the funding I receive cover the cost of implementation and delivery, and will those who fund the intervention contribute evaluation dollars that are commensurate with their expectations of what kind of evaluation they expect?
    - Will the people I serve use and think positively about the program?

3. Understand the necessary steps required to implement researched interventions before implementation begins (i.e., complexity, core elements, and the extent which adaptation can be made).
4. Explore if there are free or low cost packaged interventions available. Check to see if there is implementation training available.
5. If you have selected an intervention which appeared in a journal and a package is not yet available, contact the researcher to get complete information concerning the steps for implementation and delivery of their intervention.

ADAPT AND TAILOR

Based on your formative evaluation, you will already have some of the very important information you collected about your population and agency to assist you in the tailoring process. When you decide to adapt and tailor an intervention, the core elements can not be changed or altered. It is extremely important for you to have a general knowledge of the theory upon which the intervention is based in order to understand the core elements.

Consultation is very important when you adapt and tailor an intervention. You can receive technical assistance by:

1. Contacting the person who developed the program and seeking help in understanding what they did and how it might be accomplished in your organization.
2. Contacting an agency that has successfully implemented the same intervention with the identical population and seeking guidance.
3. Contacting a behavioral scientist to assist with this process.
4. Seeking ongoing technical assistance from one of the CDC sponsored CBA providers before, during, and after the adapt and tailor process. Technical assistance may be in one of three ways:
    - Receiving detailed procedure manuals, materials, and instructional guides on how to implement HIV risk reduction interventions.
    - Receiving the same information followed by an intensive workshop that teaches staff how to implement the intervention.
    - Receiving the training material, attending the workshop, and participating in a series of telephone consultation calls with experienced HIV prevention researchers to problem solve issues.
5. Collaborating with the researcher and the funding agency as needed.

Once having gathered your initial technical assistance, you should be ready to complete the adapt and tailor process; remembering adapting the intervention changes *who* receives the message and *where* it is delivered; tailoring the intervention changes *when* an intervention is delivered, *what* is addressed, and *how* the message is conveyed.

ADDITIONAL CONSIDERATIONS WHEN ADAPTING AND TAILORING INTERVENTIONS

Agencies should seek guidance concerning how to best use limited resources and how allocation decisions may influence effectiveness. When you adapt and tailor an intervention, remember that you should not choose application pieces of a complicated research intervention and combine them with parts of a different intervention that was developed for a similar risk group. You may feel this works best for you; however, the effectiveness of this combination is unknown.

Interventions are usually implemented in less optimal conditions than the original study (which was very controlled, had more resources, and had highly motivated or paid participants). Your intervention will be delivered under conditions which are not as controlled. It is totally understandable and desireable for agencies to implement interventions with high fidelity. Please keep in mind that fidelity versus adaptation problems increase as agencies seek to implement an intervention further from its original development and efficacy studies. (e.g., different populations, cultures, or countries). Once an intervention is adopted (by the primary population), the impact depends on implementation. The core elements must be maintained. You should also seek to achieve a balance between adaptation to suit local needs and key characteristics.

Writing the Intervention Plan

The adapted and tailored intervention plan should be written using a logic model. In the article titled "*Planning, Implementing, and Evaluating Interventions"* in the May 2005 issue of the Washington State Responds, I provided guidance for writing a logic model. As a refresher, a logic model must contain:

Problem Statement: The problem statement should be evidence-based, explain underlying causes for HIV risk, contain sufficient detail to be self-explanatory, and be based on a comprehensive needs assessment.

Implementation: Outline the items essential to the implementation of an intervention.

- Inputs –the resources used in an intervention (money, staff, curricula, and materials).
- Activities –*the services* an intervention provides to accomplish the objectives (outreach, material distribution, counseling sessions, workshops, and training). It is imperative for the intervention's core elements to appear here.
- Outputs –the direct products/deliverables of the intervention (intervention sessions completed, people reached, and materials distributed).

Outcomes: These are the expectations of the intervention.

- Immediate Outcomes – immediate results of the intervention (changes in attitudes, beliefs, and skills).
- Intermediate Outcomes – these are the results that occur some time after the intervention is completed (changes in behaviors, skills, policies, and environment).

Outcome Objectives should be written using the SMART model:

Specific – objective clearly specifies what will be accomplished and by how much

Measurable – objective is measurable

Appropriate - objective makes sense in terms of what the intervention is trying to accomplish

Realistic - objective is achievable given available resources and experience

Time-based - objective specifies when it will be achieved

Impacts: These are the long-term results of one or more interventions over time, such as changes in HIV infection, morbidity, and mortality.

Writing your intervention plan using a logic model is not limited to an adapted and tailored intervention, it can also be utilized with a non adapted and tailored intervention.

PILOT TEST

The final step prior to full implementation with your desired population is to conduct a pilot test of the intervention. If your program is CDC funded, you must submit all materials you plan to use to the State HIV/AIDS Material Panel for approval prior to using them.

When you have completed the formative evaluation, selected the intervention, adapted and tailored the intervention, written your intervention plan and received approval for using the materials (if this step is appropriate), you are ready to conduct a pilot test of the intervention. The pilot test should be conducted with a small segment of the prioritized population and must include any materials you plan to use to reach your desired population.

Completing the pilot test will provide valuable information needed prior to implementing the intervention for the full population. The segment of the population selected for the pilot test should be members of the population, but they should not have been involved in any of the intervention planning steps to this point. Using non-involved participants will ensure the outcome is accurate and not biased because the participants knew the desired outcome. The pilot test will show whether the work accomplished so far will produce the desired outcome.

The activities conducted after the pilot test are just as essential as those conducted prior to the pilot test. You will need to determine: what services were delivered to whom; whether the intervention was implemented as intended; and whether the intervention achieved its outcome objectives. You must engage the stakeholders in the process as well. This is the next appropriate place to consider if you need to adapt or tailor the intervention to meet the needs of your population. It is important to complete any additional adapting and tailoring prior to implementation for the full population intended.

ADDITIONAL HELP

How are core elements determined from reading an article?

There are five theoretical domains (risk appraisal, self-perceptions, relationships and social influence, emotion and arousal, and structural and environmental factors) which encompass the key aspects of HIV prevention. Domains are a way of categorizing and organizing determinants of behavior change; interventions are based on a theory or model (information, attitudes, beliefs, intention to change, expectation about outcomes, perceived self-efficacy) that uses exercises, procedures, and activities intended to target these same constructs. Theory driven interventions are based on factors directly responsible for risk reduction (see table); the activities that reflect these constructs would be considered core elements.

Core elements can also be judged on the basis of extensive experience with the intervention (participants' reaction, feedback about what they found useful, feedback from facilitators, research).

	Theory/Model	
Determinants (below)	**Health Belief Model**	**Stages of Change**
Perceived Susceptibility	X	
Perceived severity	X	
Perceived benefits	X	
Perceived barriers	X	
Pre-contemplation		X
Contemplation		X
Preparation		X
Action		X
Maintenance		X

WHAT DEFINES AN INTERVENTION'S SUCCESS?

Select the appropriate method to evaluate an intervention that will enable your agency to validate whether the intervention's desired outcome was achieved. Goals/desired outcomes must be identified during the initial intervention

selection process. Knowing what you want the intervention to accomplish will provide you with an idea of the tool to use in order to evaluate the outcome. Once an intervention is selected, a method to evaluate the intervention should be discussed and selected. The evaluation tool and method you select will determine whether the goal was reached (intervention success).

How do we get buy-in and disseminate the availability of an intervention?

Involve community leaders and gatekeepers in all processes. Those community members can mean the success or demise of any prevention efforts attempted; they can be a valuable allies or formidable adversaries in your HIV prevention efforts. Leaders and gatekeepers will be very helpful in reaching prioritized populations with the ultimate goal of preventing the spread of HIV.

Take Home Messages

1. Conduct a formative evaluation (population and agency) prior to selecting an intervention.
2. Involve your desired population when you select, implement, and evaluate the intervention.
3. Maintain core elements when you adapt or tailor an intervention (this is a must).
4. Consult, collaborate, and receive technical assistance throughout the process.
5. Effectiveness and fidelity of your intervention hinges on how you plan, implement, evaluate and get buy in from the priority population.
6. Realism in selecting an intervention is imperative.

Closing Thoughts

Adapting and tailoring an intervention must be well thought out processes that should not be taken lightly. Monitoring and evaluating an intervention are ongoing, starting at the beginning of the HIV prevention process, and must be thought about during the adapting and tailoring process. It is important to know that intervention activities: are conducted as intended; reached the desired population; and achieved the desired outcome.

I have provided a condensed adapt and tailor process which I developed from reading the following:

Translation, Adaptation, and Synthesis of Interventions For persons Living With HIV (Acquired Immune Deficiency Syndrome - Volume 37, Supplement 2, October 1, 2004)

Procedural Guidance for Selecting Strategies and Interventions for Community Based organizations Funded Under Program Announcement 04064 (CDC November 26, 2003)

Transfer of research-Based HIV Prevention Interventions to Community Services providers: Fidelity and adaptation (AIDS Education and Prevention, 12, Supplement A, 87-98, 2000)

Bridging the Gap Between the Science and Service of HIV Prevention: Transferring Effective Research-Based GHIV Prevention Interventions to Community ADIS Service Providers (American Journal of Public Health, July 2000, Vol. 90, No.7 1082-1088)

Adapting an Evidence-Based Intervention: Tales of the Hustler Project (AIDS Education and Prevention, 15, Supplement A, 127-138, 2003)

Bridging Theory & Practice/Interventions: Course Manual STD/HIV Prevention Training Center

Client Services

HIV Client Services Update: Medicare Part D

Due to changes in Medicare benefits effective January 1, 2006, the Early Intervention Program (EIP) provides the following document for information about how we can provide assistance to WA State residents who have Medicare and are living with HIV infection.

HIV Client Services Early Intervention Program:

Client Coverage under the Medicare Modernization Act

The United States Congress passed the Medicare Modernization Act in 2003 for the purpose of providing drug coverage for individuals enrolled in Medicare. The act contains a number of provisions that will affect how the Washington State Department of Health HIV Client Services Early Intervention Program (EIP) provides services to its clients who are eligible for Medicare. The federal government has determined how the program must respond to some provisions in the act, while the program has limited discretion to respond to other provisions. This document describes how the EIP will respond to the Medicare Modernization Act while complying with federal laws and regulations and ensuring that its clients retain access to HIV-related medications.

FEDERALLY-MANDATED ACTION:

Enrollment in prescription drug plans: The Health Resources and Services Administration (HRSA) will require that all AIDS Drug Assistance Program (ADAP) clients who are eligible for the Medicare Part D benefit enroll in a prescription drug plan (PDP).

> **Program Response:** EIP will require that all Medicare clients enroll in a PDP. In addition, EIP will require that all Medicare clients with incomes <=150% FPL apply for the Low Income Subsidy (LIS) offered through the Social Security Administration.
>
> **Rationale:** The EIP can reduce program drug costs when enrollees participate in a Prescription Drug Program. If they do not enroll, EIP would jeopardize its federal ADAP funds. Medicare beneficiaries must enroll in a PDP before May, 2006 to avoid future premium penalties. The LIS will provide premium and drug assistance for clients.

Discretionary responses to ensure coverage:

"Wrap-around" coverage: HRSA has determined that ADAPs are allowed to provide "wrap-around" coverage for clients

enrolled in a Medicare PDP. Each individual ADAP is expected to make this coverage decision. "Wrap-around" coverage includes the paying of premiums, deductibles, co-pays and any other co-insurance.

Response: EIP will pay PDP premiums and will offer to pay co-pays or a percentage of drug costs (co-insurance) for EIP formulary medications for program participants enrolled in a PDP (or a Medicare Advantage plan that includes prescription coverage.) EIP will assist clients with their co-pays or the percentage of their drug costs described below.

Rationale: Paying PDP premiums, co-pays, and co-insurance will reduce interruptions to HIV drug treatment, which are dangerous and can lead to drug resistance. Medicare beneficiaries will be faced with the following costs that could result in a disruption to care:

1. PDP's will have tiered systems that provide additional formulary coverage at a higher premium rate. Dual eligibles (Medicaid/Medicare recipients) and Medicare beneficiaries with LIS will only receive the basic coverage and will need to purchase additional coverage if their medication is not included on the formulary.
2. All Medicare beneficiaries will have a financial requirement regardless of income level.
3. Drug costs will range from 15% to 25% of monthly prescription costs for individuals over 135% FPL.
4. Co-pays will range from $1 to $5 dollars per prescription, per month for individuals <=135% FPL.

Insurance coverage: ADAPs may provide insurance coverage to individuals on Medicare who have creditable insurance (plans comparable to PDPs).

Response: EIP will continue to pay insurance premiums for Medicare clients who have creditable insurance if their income is >=135% FPL or they do not qualify for LIS. EIP will no longer pay insurance premiums for Medicare clients with incomes <135% FPL or who qualify for LIS.

Rationale: Medicare clients with incomes <135% will have coverage equal to clients with both Medicare and Medicaid. These clients will be referred to Social Security Administration for LIS. If they do not qualify for LIS, EIP will continue to assist with insurance premiums payments.

Spenddown coverage: EIP assists clients with Medicaid spenddown using unobligated state funds. Clients eligible for both Medicaid and Medicare are considered dual eligibles. Dual eligibles who maintain their Medicaid coverage have access to comprehensive insurance coverage. Assisting clients to meet their Medicaid spenddown reduces potential interruptions in health care.

Response: EIP will continue to assist Medicare clients to meet their Medicaid spenddown if their incomes are >=135% FPL or they do not qualify for LIS. Once their spenddown is met, these clients will be considered eligible for LIS for the remainder of the calendar year. EIP will no longer assist Medicare clients to meet their Medicaid spenddown if their incomes are <135% FPL.

Rationale: Medicare clients with incomes < 135% who do not meet their Medicaid spenddown will be referred Social Security Administration for LIS and the Department of Social and Health Services for the Medicare Savings Program. This will provide them with coverage similar to coverage for duals. Medicare clients with incomes

>=135% FPL who do not meet their Medicaid spenddown will not be eligible for full subsidy LIS or Medical Savings Program and will therefore have higher coinsurance and insurance premiums.

For more information please contact HIV Client Services at 1-360-236-3426 or 1-877-376-9316

Revised EIP Application

EIP has revised our application which should now be used by all new and renewing clients. Both the English and Spanish versions of the application will soon be available to be downloaded and printed from our website:**http://www.doh.wa.gov/cfh/HIV_AIDS/Client_Svcs/default.htm**

To have an application mailed out to you, call our toll free number at: 1-877-376-9316.

Early Intervention Program Contact numbers:

Medical and laboratory billing --Lorie Wharton (360) 236-3489.

Client Services Representatives (CSRs) assist clients according to the first letter of the client's last name as follows:

A - E Lori Miller (360) 236-3493

F - N Ngozi Mbanugo (360) 236-3435

O - Z Abby Gilliland (360) 236-3452

For general information on the Early Intervention Program contact Teri Eyster Hintz at (360) 236-3449.

The STD Focus

By Bonnie Nickle; DOH STD Educational Resource Coordinator

What are STEDs? Why Do I Need to Know About Them?

Here at Washington State Department of Health we have been getting calls for information on enteric diseases. Many have been from people who have been traveling, but educators, caseworkers and caregivers have had questions too. So, we are passing along some brief notes for your files.

STEDs are **Sexually Transmitted Enteric Diseases.** Some common causes are shigellosis, salmonellosis, giardiasis, cryptosporidiosis and hepatitis A. There are many more.

As with the STDs you already know, there can be more than one strain associated with a particular species that causes enteric infection. Just as we had to learn that LGV was part of the chlamydia family, the various strains of enteric infections may have different names, different symptoms, different time frames and different locations in the body.

"Enterikos" comes from the Greek word for things relating to the intestine. These diseases involve contact with feces. They can also be **Sexually Transmitted Intestinal Syndromes (STIS).** Or, Sexually Transmitted Gastrointestinal Syndromes. You already know the familiar STDs such as gonorrhea, syphilis and herpes can be present and passed to and from the anal/rectal area.

So is this just about gay males? Are they always sexually transmitted? No, not just gays and not just men. Enteric infections can have bacterial, viral, parasite and other causes. Some of these diseases are important opportunistic infections related to HIV and may not be sexually transmitted at the time they present as immune system opportunistic infections.

Women and children are at risk too. These diseases are also associated with food borne illness, contaminated water borne illness, travel, child care, other human or animal contact and chaotic behavior related to drug use, especially methamphetamine use where participants stay high for many hours or days.

Outreach workers need to know about STEDs because they deal with high risk folks and may be consulted by clients who need a brief overview and referral. In particular, you may be consulted by DSHS, child protective services, law enforcement, or firefighters after a first encounter with extremely chaotic people, meth labs or other drug manufacturing site inhabitants.

As with more familiar STDs, there can be more than one infection at a time, some with symptoms, and some without. The 2002 STD Treatment Guidelines (new guidelines expected in '06) remind us that re-infection may be difficult to distinguish from treatment failure.

Women who have anal intercourse need information and referral and, perhaps, coaching if they are hesitant to report symptoms or behavior important for a complete exam. Keep in mind the "slither factor." Germs can slide from one part of the genitals to another. In a review of papers on gonorrhea in women, rectal gonorrheal was present in 26 to 63% of patients and in up to 20% it was the only site of infection. Role-play so that a matter- of-fact request for an anal exam can be part of a medical check up.

No need to sort out signs, symptoms, and causative agents – the clinicians and the lab tests will do that. What you can do

is fast forward people to medical attention. One very important role of the outreach worker is getting the client to disclose possible contact with feces or other risks. Demonstrate how to say this in a calm way.

Don't forget travel and toys. You're already an expert on your clients and their behavior, but some clients think "travel" means foreign travel. A trip to visit Aunt Doris in Wisconsin could have meant Campylobacteriosis (in Milwaukee) a few years ago. More general geography is important, too. Giardiasis may be seen in wilderness hikers. Disease transmission or trauma (injury) from sex toys means that your coaching for a good history is important.

Your clients also need to know that some tests require "special" (euphemism for difficult or embarrassing) preparation and that in order to get the best and most specific diagnosis, more than one set of tests may be necessary. If it is definite that your client has recently practiced receptive anal intercourse, has symptoms, and certain preliminary tests are positive, immediate treatment may be given PENDING results of additional tests and reaction to initial medications. Let your clinic staff know that you are available if more tests are needed or if new lab results change what is needed for or from your client.

Your client may be given a general diagnosis (or more than one diagnosis) in one of four broad categories having to do with body part location. Some germs attack particular parts, some cause more general damage. You will hear of:

1. Perianal diseases ('peri' is Greek for around, so "around the anal area" is the location).
2. Proctitis has to do with conditions limited to the rectum, which is the last 10 to 15 centimeters (there are about 2 ½ centimeters to one inch) as we travel down and out to the anus. "Proctos" is Greek for anus and "itis" just means inflammation. Proctitis symptoms can include (but are not limited to) discharges of mucus, pus or blood, pain, itching, burning or painful efforts to pass stool which clinicians may call tenesmus (feeling like you have to defecate, but can't) rectal fullness or constipation.
3. Proctocolitis is the word used to describe inflammation of the colon 15 centimeters or more above the proctitis line and could include the proctitis symptoms PLUS watery diarrhea.
4. Enteritis can include diarrhea and cramping without the signs listed for proctitis and protocolitis. In Washington State giardiasis is one enteric infection that might be considered for this category.

This list does not do justice to the ability of enteric infections to cause great misery and surprise in your clients as in "I never thought I could feel this bad."

Plan to stay in touch with your client and clinicians, since partners may have to be notified and some infections can last for very long periods of time.

There are long lists of causative agents for the conditions listed above, but what is the meaning of this osis/iasis stuff? You already know that "itis" at the end of a word just means inflammation (hepatitis is inflammation of the liver). "Osis" is a Greek ending for words that have to do with a process or condition, usually abnormal or diseased. You are familiar with **tuberculosis, endometriosis, bacterial vaginosis.** Or, it can mean an invasion or increase within an organism of parasites. When parasites are in the picture, the ending "iasis" is often used. It means the same thing. Think "**trichomoniasis."**

If your client has high-risk drug behavior or is worried about a child living in a feces-smeared environment, talk about the best clinic or person to see, but do not lie about endangerment reporting requirements. Often outreach workers are the best contacts for substance abuse treatment options and the availability of openings at the various treatment facilities.

None of your clients who are HIV positive can be left to deal with diarrhea or bloody diarrhea and severe dehydration alone. Time for a quick transit to medical care if you even suspect this.

Selected Readings

How to Read the References

Author(s), "Title," *Journal Name*, Date or Year; Volume (Number): Pages.

Key:

* Popular Reading
** Moderate Difficulty; Some Understanding Of Medical Terms
*** Medical Background Needed
**** Technical Reading.

Hepatitis

** Iorio R., Giannattasio A., Sepe A. and others. "Chronic Hepatitis C in Childhood: An 18-Year Experience." *Clinical Infectious Diseases.* November 15, 2005;41(10): 1431-1437.

*** Bair R.M., Baillargeon J.G., Kelly P.J. and others. "Prevalence and Risk Factors for Hepatitis C among Adolescents in Detention." *Archives of Pediatrics and Adolescent Medicine.* November 25, 2005;159(11):1015-1018. Injection drug use was linked to the majority of cases. As with adult populations, the overall prevalence was 2.0%.

*** Kolor B. "Education and Treatment Strategies at a Pharmacist-Managed Hepatitis C Clinic." *Pharmacotherapy.* 2005;25 (9):1230-1241. Material for patients and mid-level clinicians on managing side effects and protocols for entry into a treatment program. http://www. medscape.com/viewarticle/515318_1.

*** Byun K.S., Kwon O.S., Kim J.H. "Factors Related to Post-Treatment Relapse in Chronic Hepatitis B Patients Who Lost HBeAg After Lamivudine Therapy." *Journal of Gastroenterology and Hepatology.* 2005;20(12):1838-1842. http://www.medscape.com/viewarticle/516580?src=mp.

Family Planning

*** ACOG Committee on Gynecologic Practice. "Committee Opinion: The Importance of Preconception Care in the Continuum of Women's Health Care." *Obstetrics and Gynecology.* September 2005;106(3):665-666.

**** Misra D.P., Guyer B., Allston A. "Integrated Perinatal Health Framework." *American Journal of Preventive Medicine. 2003;25(1):65-74.* This 2003 article on pre-conception and interconceptional family planning models provides indicator measures for health disparities.

*** Lobo R.A. "Potential Options for Preservation of Fertility in Women." *New England Journal of Medicine.* July 7, 2005;353(1):64-71. Identifying women who are at risk for early ovarian failure and exploring options.

** Wood. S.F. "Women's Health and the FDA." *New England Journal of Medicine.* October 20, 2005;353(16):1650-1651. Dr. Wood resigned from the FDA over the delay in approving OTC Plan B emergency contraception.

** Wood J.J., Drazen J.M., Greene M.F. "A Sad Day for Science at the FDA." *New England Journal of Medicine.* September 22, 2005;353(12):1197-1199. Over-the-counter emergency contraception and the FDA advisory board.

** "Good Laboratory Practices for Waived Testing." *MMWR*. November 11, 2005;54 (RR13); 1-25. Quality concerns. **http://www.cdc.gov/mmwr/preview/mmwrhtml/ rr5413a1.htm**

* Bensyl D.M, Iuliano A.D., Carter M. and others. "Contraceptive Use --- United States and Territories, Behavioral Risk Factor Surveillance System 2002." *MMWR*. November 18k 2005; 54(SS06):1-72. The 2002 Behavioral Risk Surveillance System (BRFSS) data represent the first time state data on contraceptive use in all 50 states and territories was collected and the first time contraceptive use patterns among men were examined at a state level.

** Hutchinson J.W., Stafford E.M. "Changing Parental Opinions about Teen Privacy Through Education." *Pediatrics*. October 2005;116:966-971.

*** Peterson H.B., Curtis K.M. "Long-Acting Methods of Contraception." *New England Journal of Medicine*. November 17, 2005;353(20):2169-2176. Case Study: A review of methods for an irregular pill user.

** Grimley D.M., Oh M.K., Desmond R.A. and others. "An Intervention to Reduce Vaginal Douching Among Adolescent and Young Adult Women." *Sexually Transmitted Diseases*. December 2005;32(12):752-758. Among adolescents, 37% of black and 11% of white girls reported regular douching and the behavior is being initiated at earlier ages. In this randomized controlled trial there was a 50% reduction in douching at the 12-month assessment of 3 15-minute counseling sessions. At the time of enrollment, 90% of young women in the intervention group reported having no intention to stop douching.

** Nicholson W., Bardner B., Grason H.A.,Powe N.R. "The Association Between Women's Health Information Use and Health Care Visits." *Women's Health Issues*. 2005;15:240-248. There is a difference in computer use within income, age, educational and racial groups.

*** Sutton M.Y., Sternberg M., Aidi A. and others. "Trends in Pelvic Inflammatory Disease Hospital Discharges and Ambulatory Visits, United States, 1985—2001." *Sexually Transmitted Diseases*. December 2005;32(12):778-784. The expanded national surveys in outpatient and EDs provide more complete estimates for PID.

*** Boatwright E.A., Tozer B.S., Verma D.P. and others. "Health Care Maintenance in Female Adolescents." *Mayo Clinic Proceedings*. December 2005;80(12):1641-1650. Concise review.

Harm Reduction

*** Friedman S.R., Cooper H.L.F., Tempalski B. and others. "Relationships of Detererrence and Law Enforcement to Drug-Related Harms among Drug Injectors in US Metropolitan Areas." *AIDS*. January 2006;20(1):93-99.

**** Sobel J. "Botulism." *Clinical Infectious Diseases*. October 15, 2005;41(8):1167-1173. Review article with large section on wound botulism related to illegal IV drug use.

**** Gordon R.J., Lowy F.D. "Bacterial Infections in Drug Users." *New England Journal of Medicine*. November 3, 3005;353 (18): 1945-1953. Review article – good material for clinical students and those new to outreach work. Includes chart with suggested tests and treatment options for various clinical scenarios.

HIV/AIDS

** "Supplemental Testing for Confirmation of Reactive Oral Fluid rapid HIV Antibody Tests." *MMWR Dispatch*. December 16, 2005, Vol 54. There have been reports of false positive test results for the OraQuick® Rapid HIV-1

Antibody Test. CDC is working with the FDA, state and local health officials and the test manufacturer to investigate this matter. Counselors must stress the need for test confirmation.

**** Riley L.E., Yawetz S. "A 34-Year-Old- HIV- Positive Woman Who Desired to Become Pregnant." *New England Journal of Medicine.* October 20,2005;353(16):1725-1732. Counseling, management, HSV infection in third trimester, HPV, antiretrovirals, labor and delivery and treatment and monitoring of the infant.

**** Gigliotti F. "*Pneumocystis carinii:* Has the Name Really Been Changed?" *Clinical Infectious Diseases.* December 15, 2005;41 (12):1752-1755. Until this issue is decided, try both *P. jirovecii* and *P. carinii* when checking on opportunistic infection information.

** Zaidi I.F., Crepaz N., Song R. and others. "Epidemiology of HIV/AIDS among Asians and Pacific Islanders in the United States." *AIDS Education and Prevention.* October 2005;17(5):405-417. The entire October issue of this journal is devoted to APIs, including articles on MSM, transgendered women, substance abuse, college students, STDs, and condom use negotiation at massage parlors.

** Espinoza L., Hall H.I., Campsmith M.L. and others. "Trends in HIV/AIDS Diagnoses --- 33 States, 2001—2004." *MMWR.* November 18, 2005;54(45):1149-1153.

** Frieden T.R., Das-Douglas M., Kellerman S.E. "Applying Public Health Principles to the HIV Epidemic." *New England Journal of Medicine.* 353(22):2397-2402.

*** Gutiérrez F., Navarro A., Padilla S. and others. "Prediction of Neuropsychiatric Adverse Events Associated with Long-Term Efavirenz Therapy, Using Plasma Drug Level Monitoring." *Clinical Infectious Diseases.* December 1, 2005;41(11):1648-1653. Includes interview chart for exploring neuropsychiatric adverse effects and plasma level monitoring to optimize management.

*** Roland M.E., Neilands T.B., Krone M.R. and others. "Seroconversion Following Nonoccupational Postexposure Prophylaxis against HIV." *Clinical Infectious Diseases.* November 15,2005;41(10):1507-1513. San Francisco evaluation of 702 patients.

STD

*** Fredericks D.N., Fiedler T.L. Marrazzo J.M. "Moledular Identification of Bacteria Associated with Bacterial Vaginosis." *New England Journal of Medicine.* November 3, 2005*;353(18):1899-1911.* New technologies, new complexities. Still no definitive cause. The authors include a clear outline of the limitations of the technology used for this study.

*** Wald A., Langenberg A.G.M., Krantz E., and others. "The Relationship between Condom Use and Herpes Simplex Virus Acquisition." *Annals of Internal Medicine.* November 15, 2005;143(10):707-713. The authors conclude that consistent use of condoms is associated with lower rates of HSV-2 infection and should be routinely recommended.

**** Sawtell N.M., Thompson R.L., Haas R.L. "Herpes Simplex Virus DNA Synthesis Is Not a Decisive Regulatory Event in the Initiation of Lytic Viral Protein Expression in Neurons In Vivo during Primary Infection or Reactivation from Latency." *Journal of Virology.* January 2006;80(1):38-50. New strategies and analysis related to basic science and herpes latency.

*** Golden M.R. Ashley-Morrow R., Swenson P. and others. "Herpes Simplex Virus Type 2(HSV-2) Western Blot Confirmatory Testing Among Men Testing Positive for HSV-2 Using the Focus Enzyme-Linked Immonosorbent Assay in a Sexually Transmitted Disease Clinic." *Sexually Transmitted Diseases.* December 2005;32(12):771-777. Clinicians should consider selectively using a higher index value to define Focus ELISA HSV-2 positivity based on either HSV-1 serostatus or clinical circumstances. The authors propose a new algorithm for interpreting serologies that includes a newly defined group of indeterminate results.

*** Samoff E., Koumans E.H., Markowitz L.E. and others. Association of *Chlamydia trachomatis* with Persistence of High-Risk Types of Human Papillomavirus in a Cohort of Female Adolescents." *American Journal of Epidemiology.* October 1, 2005;167(7):668-675.

** Hwang L.Y., Tebb K.P., Shafer M-A.B. and others. "Examination of the Treatment and Follow-up Care for Adolescents Who Test Positive for *Chlamydia trachomatis* Infection." *Archives of Pediatric and Adolescent Medicine.* December 2004;159(12):1152-1155.

*** Aral S.O., Patel D.A., Holmes K.K. and others. "Temporal Trends in Sexual Behaviors and Sexually Transmitted Disease History Among 18- to 39- Year Old Seattle, Washington Residents: Results of Random Digit-Dial Surveys." *Sexually Transmitted Diseases.* November 2005; 32(11): 710-717. Some risk behaviors including douching declined, while anal sex and number of sex partners increased since 1995.

** Sadiq S.T., McSorley J., Copas A.J. and others. "The Effects of Early Syphilis on CD4 Counts and HIV-1RNA Viral Loads in Blood and Semen." *Sexually Transmitted Infections.* December 2005*;81:380-385.* The authors state that they detected no association at 1, 3, and 6 months after treatment.

*** Wisenfeld H.C., Kennard-Hall K., Cook R.L. and others. "Knowledge About Sexually Transmitted Diseases in Women Among Primary Care Physicians." *Sexually Transmitted Diseases.* November 2005;32(11):649-653. Continuing medical education and distribution of CDC's treatment guidelines were seen by the authors as interventions to improve management practices. Physicians with good STD knowledge were more likely to report routine screening of at-risk women for chlamydia.

TUBERCULOSIS

*** Taylor Z., No C.M., Blumberg H.M. "Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Disease Society of America." *Morbidity and Mortality Weekly Report.* November 4, 2005;54(RR 12):1-81. Update and guide for the diagnosis, control and treatment of TB.

*** "Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC." *MMWR Recommendations and Reports.* December 16, 2005;54(RR-15):1-37. **http://www.cdc.gov/ mmwr/preview/mmwrhtml/rr5415a1.htm?s_cid=rr5415a1_e**

**** Freeman R., Kato-Maeda M., Hauge K.A. and others. "Use of Rapid Genomic Deletion Typing To Monitor a Tuberculosis Outbreak within an Urban Homeless Population." *Journal of Clinical Microbiology.* November 2005;43 (11):5550-5554. The authors state that the use of this technology (PCR genomic-deletion typing) during a Seattle outbreak was cost effective.

**** Kremer K., Arnold C., Cataldi A., and others. "Discriminatory Power and Reproducibility of Novel DNA Typing Methods of *Mycobacterium tuberculosis Complex* Strains." *Journal of Clinical Microbiology.* November 2005;43(11):5628-

5638. Evaluation of nine PCR-based typing methods.

*** The Antiretroviral Therapy Cohort Collaboration. "Incidence of Tuberculosis among HII-Infected Patients Receiving Highly Active Antiretroviral Therapy in Europe and North America." *Clinical Infectious Diseases.* December 15, 2005;41(12):1772-1782.

*** Shams H., Weis S.E., Klucar P. and others. "Enzyme-linked Immunospot and Tuberculin in Skin Testing to Detect Latent Tuberculosis Infection." *Respiratory and Critical Care Medicine.* November 2005;172(9):1161-1168.

*** "Guidelines for Using the QuantiFERON® -- TB Gold Test for Detecting *Mycobacterium tuberculosis Infection,* United States." *MMWR.* December 16, 2005;54 (RR-15):49-55. **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5415a4.htm?s_cid=rr5415a4_e**

*** Perlman D.C., Segal Y., Rosencranz S. and others for the AIDS Clinical Trials Group 309 Team. "The Clinical Pharmacokinetics of Rifampin and Ethambutol in HIV-Infected Persons with Tuberculosis." *Clinical Infectious Diseases.* December 1, 2005;41(11):1638-1647. Monitoring to achieve target serum concentrations.

*** Schwartzman K., Oxlade O., Barr R.G., and others. "Domestic Returns from Investment in the Control of Tuberculosis in Other Countries." *New England Journal of Medicine.* September 8, 2005;353(10): 1008-1020. The author's fiscal hypothesis/decision analysis model showed U.S.-funded efforts to expand the DOTS program in Mexico, Haiti, and the Dominican Republic could reduce TB-related morbidity and mortality among migrants to the U.S.

**** Kaplan G. "Rational Vaccine Development---A New Trend in Tuberculosis Control." *New England Journal of Medicine.* October 13, 2005;1624-1625. The immune response to mycobacteria relies on T-cell, not antibody production. A proposed vaccine, soon to go into phase 1 clinical trial relies on recombinant and gene technology to produce antigens.

**** Gelperina S., Kisich K., Iseman M.D. "The Potential Advantages of Nanoparticle Drug Delivery Systems in Chemotherapy of Tuberculosis." *Respiratory and Critical Care Medicine.* December 15, 2005;172(12):1487-1490. Sustained release, high stability, and other bioavailability issues in the context of non-adherence and high technology.

** Ross J.J. "Tuberculosis, Brochiectasis, and Infertility: What Ailed George Orwell?" *Clinical Infectious Diseases.* December 1, 2005;41(11):1599-1603. From high school to med school-- speculation and great stuff for students.

** Markel H. "Medical History: The Medical Detectives." *New England Journal of Medicine.* December 8, 2005;353 (23):2426-2428. Robert Koch, Sherlock Holmes, and some of the early mysteries of TB.

** Kaufmann S.H.E. "Robert Koch, the Nobel Prize, and the Ongoing Threat of Tuberculosis." *New England Journal of Medicine.* December 8, 2005;353(23):2423-2426. Success (tuberculin as diagnostic tool) and failure (remedy) for TB. Fine material for clinical and non-clinical students.

If you do not have access to library services, please call Bonnie Nickle at (360) 236-3498 for single copies of the articles listed.

Other Health Resources

Community health assessment is the work of collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public health. **AssessNow provides public health staff with information, tools, and resources to improve the practice of community health assessment.** Go to **http://www.assessnow.info/ to explore this resource.**

A **case study addressing genital herpes simplex virus (HSV)** has been added to the National Network of STD/HIV Prevention Training Centers' Online STD Case Series at **www.STDcases.org**.

An updated (November 3, 2005) version of "**Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection**" is available at **http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=51**.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5449a5.htm?s_cid=mm5449a5_e is an MMWR "Quick Stat" on US birth rates by state.

http://www.fda.gov/cdrh/comp/guidance/1548.html is the web address for the **FDA's draft guidelines on condoms** submitted for comments for 90 days beginning November 14, 2005, "Class II Special Controls guidance Document: Labeling for Male Condoms Made of Natural Rubber Latex."

Looking for information on **TB and HIV co-infection?** The article, "Treatment of Tuberculosis in Patients Infected with HIV: An Update," is available online at: **http://ccoe. umdnj.edu/online/em/07HC06-DE02/ index.htm.** This article is available for 1 AMA Category I credit (free) through the University of Medicine and Dentistry of NJ.

Hepatology experts answer your questions on hepatitis B, how to understand lab work, monitoring, recurrence, medications and prevention at **http://www.hivandhepatitis.com/doctor/topics/hbv1. html #112805a.**

"Tuberculosis and Nontuberculosis Mycobacterial Infections." Author: David Schlossberg. New York: McGraw-Hill. $99.95 ISBN 0071439137.

"When a Son is Gay" **http://www.realhealthmag.com/articles/366_2161.shtml** is a featured article in Real Health, A Guide to Black Wellness.

http://www1.dshs.wa.gov/esa/eazmanual/Sections/EA_AlienMedical.htm is the address for Washington state's **DSHS manual for emergency medical care** for low income refugees and non-citizens.

"Bugs In The News" helps kids (and grownups) **understand bacteria, viruses, and antibodies** **http://people.ku.edu/~jbrown/bugs.html**. An American Library Association-recommended site.

TABLE 1. WASHINGTON STATE HIV[1] AND AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, AS OF 12/31/2005

	TOTAL CASES (& CASE FATALITY RATE[2]) DIAGNOSED DURING INTERVAL[3]					DEATHS OCCURRING DURING INTERVAL[4]		CASES PRESUMED LIVING DIAGNOSED DURING INTERVAL[3]		
	HIV[1]		AIDS		**HIV/AIDS**	*HIV[1]*	AIDS	*HIV[1]*	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**Total**	*No.*	No.	*No.*	No.	**Total**
1982	2	*(0%)*	1	(100%)	**3**	*0*	0	2	0	**2**
1983	5	*(20%)*	20	(100%)	**25**	*0*	7	4	0	**4**
1984	7	*(0%)*	79	(97%)	**86**	*0*	31	7	2	**9**
1985	68	*(12%)*	132	(98%)	**200**	*0*	81	60	3	**63**
1986	59	*(15%)*	245	(98%)	**304**	*0*	126	50	5	**55**
1987	72	*(17%)*	370	(96%)	**442**	2	188	60	15	**75**
1988	84	*(17%)*	493	(94%)	**577**	6	236	70	28	**98**
1989	115	*(17%)*	611	(92%)	**726**	8	309	96	49	**145**
1990	137	*(20%)*	733	(91%)	**870**	6	371	110	63	**173**
1991	148	*(12%)*	835	(88%)	**983**	4	461	130	99	**229**
1992	135	*(11%)*	897	(79%)	**1,032**	7	515	120	187	**307**
1993	117	*(11%)*	943	(71%)	**1,060**	12	617	104	276	**380**
1994	171	*(7%)*	853	(59%)	**1,024**	10	676	159	348	**507**
1995	181	*(6%)*	754	(42%)	**935**	6	665	171	441	**612**
1996	225	*(5%)*	662	(28%)	**887**	7	495	213	475	**688**
1997	226	*(5%)*	512	(22%)	**738**	10	226	214	399	**613**
1998	219	*(2%)*	385	(24%)	**604**	6	167	214	291	**505**
1999	275	*(2%)*	351	(24%)	**626**	7	137	269	268	**537**
2000	337	*(3%)*	430	(20%)	**767**	34	165	326	343	**669**
2001	312	*(1%)*	389	(15%)	**701**	24	153	309	330	**639**
2002	309	*(2%)*	413	(12%)	**722**	23	157	302	363	**665**
2003	324	*(1%)*	421	(10%)	**745**	29	184	322	377	**699**
2004[5]	333	*(0%)*	400	(7%)	**733**	10	152	333	374	**707**
2005 YTD[5]	349	*(1%)*	363	(4%)	**712**	8	87	346	350	**696**
TOTAL	*4,210*	*(5%)*	11,292	(55%)	**15,502**	*219*	6,206	*3,991*	5,086	**9,077**

TABLE 2. WASHINGTON STATE HIV[1] AND AIDS CASES, GENDER BY AGE AT DIAGNOSIS

	HIV[1]						AIDS					
	Male		*Female*		*Total*		Male		Female		Total	
	No.	*(%)*	*No.*	*(%)*	*No.*	*(%)*	No.	(%)	No.	(%)	No.	(%)
Under 13	17	*(0%)*	21	*(0%)*	*38*	*(1%)*	15	(0%)	17	(0%)	32	(0%)
13-19	61	*(1%)*	40	*(1%)*	*101*	*(2%)*	32	(0%)	12	(0%)	44	(0%)
20-29	1151	*(27%)*	224	*(5%)*	*1,375*	*(33%)*	1658	(15%)	231	(2%)	1,889	(17%)
30-39	1492	*(35%)*	179	*(4%)*	*1,671*	*(40%)*	4736	(42%)	388	(3%)	5,124	(45%)
40-49	703	*(17%)*	101	*(2%)*	*804*	*(19%)*	2762	(24%)	231	(2%)	2,993	(27%)
50-59	161	*(4%)*	32	*(1%)*	*193*	*(5%)*	827	(7%)	98	(1%)	925	(8%)
60+	24	*(1%)*	4	*(0%)*	*28*	*(1%)*	250	(2%)	35	(0%)	285	(3%)
TOTAL	*3,609*	*(86%)*	*601*	*(14%)*	*4,210*	*(100%)*	10,280	(91%)	1012	(9%)	11,292	(100%)

1 Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

2 Case fatality rate is the proportion of HIV or AIDS patients diagnosed during interval who are known to have died at some time since diagnosis.

3 Year of diagnosis reflects the time at which HIV infection or AIDS was diagnosed by a health care provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

4 Includes deaths among HIV or AIDS patients diagnosed during that interval or any preceding interval.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

IDRH Assessment Unit, P.O. Box 47838, Olympia, WA 98504-7838; (360) 236-3455.

TABLE 3. WASHINGTON STATE HIV[1] CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 12/31/2005

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	2706	(75%)	299	(52%)	14	(36%)	3019	(72%)
Black, not Hispanic	427	(12%)	182	(31%)	15	(38%)	624	(15%)
Hispanic (All Races)	281	(8%)	53	(9%)	6	(15%)	340	(8%)
Asian/Pacific Islander	2	(0%)	4	(1%)	0	(0%)	6	(0%)
Asian	86	(2%)	10	(2%)	4	(10%)	100	(2%)
Hawaiian/Pacific Islander	6	(0%)	1	(0%)	0	(0%)	7	(0%)
Native American/Alaskan	35	(1%)	27	(5%)	0	(0%)	62	(1%)
Multi-race	16	(0%)	1	(0%)	0	(0%)	17	(0%)
Unknown	32	(1%)	3	(1%)	0	(0%)	35	(1%)
Total	3,591	(100%)	580	(100%)	39	(100%)	4,210	(100%)
Exposure Category								
Male/male sex (MSM)	2621	(73%)	0	(0%)	0	(0%)	2621	(62%)
Injecting Drug Use (IDU)	241	(7%)	143	(25%)	0	(0%)	384	(9%)
MSM and IDU	354	(10%)	0	(0%)	0	(0%)	354	(8%)
Transfusion/Transplant	9	(0%)	11	(2%)	0	(0%)	20	(0%)
Hemophilia	12	(0%)	1	(0%)	1	(3%)	14	(0%)
Heterosexual Contact[6]	129	(4%)	282	(49%)	0	(0%)	411	(10%)
Mother at Risk for HIV	0	(0%)	0	(0%)	35	(90%)	35	(1%)
No Identified Risk[7]/Other	225	(6%)	143	(25%)	3	(8%)	371	(9%)
Total	3,591	(100%)	580	(100%)	39	(100%)	4,210	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 4. WASHINGTON STATE AIDS CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 12/31/2005

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	8151	(79%)	543	(55%)	15	(47%)	8709	(77%)
Black, not Hispanic	984	(10%)	271	(27%)	10	(31%)	1265	(11%)
Hispanic (All Races)	750	(7%)	87	(9%)	4	(13%)	841	(7%)
Asian/Pacific Islander	31	(0%)	13	(1%)	1	(3%)	45	(0%)
Asian	128	(1%)	17	(2%)	0	(0%)	145	(1%)
Hawaiian/Pacific Islander	21	(0%)	7	(1%)	0	(0%)	28	(0%)
Native American/Alaskan	158	(2%)	50	(5%)	1	(3%)	209	(2%)
Multi-race	31	(0%)	5	(1%)	1	(3%)	37	(0%)
Unknown	11	(0%)	2	(0%)	0	(0%)	13	(0%)
Total	10,265	(100%)	995	(100%)	32	(100%)	11,292	(100%)
Exposure Category								
Male/male sex (MSM)	7470	(73%)	N/A	( )	0	(0%)	7470	(66%)
Injecting Drug Use (IDU)	743	(7%)	287	(29%)	0	(0%)	1030	(9%)
MSM and IDU	1116	(11%)	N/A	( )	0	(0%)	1116	(10%)
Transfusion/Transplant	73	(1%)	52	(5%)	0	(0%)	125	(1%)
Hemophilia	83	(1%)	4	(0%)	4	(13%)	91	(1%)
Heterosexual Contact[6]	299	(3%)	497	(50%)	0	(0%)	796	(7%)
Mother at Risk for HIV	0	(0%)	0	(0%)	28	(88%)	28	(0%)
No Identified Risk[7]/Other	481	(5%)	155	(16%)	0	(0%)	636	(6%)
Total	10,265	(100%)	995	(100%)	32	(100%)	11,292	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

TABLE 5. WA STATE HIV[1] & AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, BY COUNTY OF RESIDENCE[8] AT DIAGNOSIS, AS OF 12/31/2005

	CASES DIAGNOSED					DEATHS				PRESUMED LIVING				
	HIV[1]	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**	*HIV[1]*	*HIV[1]*	AIDS	AIDS	*HIV[1]*	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**TOTAL**	*No.*	*(%)*	No.	(%)	*No.*	*(%)*	No.	(%)	**TOTAL**
REGION 1	*176*	*(4.2%)*	630	(5.6%)	**806**	*14*	*(6.4%)*	340	(5.5%)	*162*	*(4.1%)*	290	(5.7%)	**452**
ADAMS CO.	*1*	*(0.0%)*	5	(0.0%)	**6**	*0*	*(0.0%)*	1	(0.0%)	*1*	*(0.0%)*	4	(0.1%)	**5**
ASOTIN CO.	*4*	*(0.1%)*	15	(0.1%)	**19**	*1*	*(0.5%)*	6	(0.1%)	*3*	*(0.1%)*	9	(0.2%)	**12**
COLUMBIA CO.	*1*	*(0.0%)*	4	(0.0%)	**5**	*0*	*(0.0%)*	3	(0.0%)	*1*	*(0.0%)*	1	(0.0%)	**2**
FERRY CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	6	(0.1%)	*0*	*(0.0%)*	1	(0.0%)	**1**
GARFIELD CO.	*1*	*(0.0%)*	0	(0.0%)	**1**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	0	(0.0%)	**1**
LINCOLN CO.	*0*	*(0.0%)*	4	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*0*	*(0.0%)*	2	(0.0%)	**2**
OKANOGAN CO.	*7*	*(0.2%)*	26	(0.2%)	**33**	*0*	*(0.0%)*	9	(0.1%)	*7*	*(0.2%)*	17	(0.3%)	**24**
PEND OREILLE CO.	*1*	*(0.0%)*	8	(0.1%)	**9**	*0*	*(0.0%)*	5	(0.1%)	*1*	*(0.0%)*	3	(0.1%)	**4**
SPOKANE CO.	*147*	*(3.5%)*	477	(4.2%)	**624**	*12*	*(5.5%)*	267	(4.3%)	*135*	*(3.4%)*	210	(4.1%)	**345**
STEVENS CO.	*6*	*(0.1%)*	19	(0.2%)	**25**	*0*	*(0.0%)*	10	(0.2%)	*6*	*(0.2%)*	9	(0.2%)	**15**
WALLA WALLA CO.	*8*	*(0.2%)*	52	(0.5%)	**60**	*1*	*(0.5%)*	27	(0.4%)	*7*	*(0.2%)*	25	(0.5%)	**32**
WHITMAN CO.	*0*	*(0.0%)*	13	(0.1%)	**13**	*0*	*(0.0%)*	4	(0.1%)	*0*	*(0.0%)*	9	(0.2%)	**9**
REGION 2	*140*	*(3.3%)*	383	(3.4%)	**523**	*9*	*(4.1%)*	185	(3.0%)	*131*	*(3.3%)*	198	(3.9%)	**329**
BENTON CO.	*27*	*(0.6%)*	78	(0.7%)	**105**	*1*	*(0.5%)*	37	(0.6%)	*26*	*(0.7%)*	41	(0.8%)	**67**
CHELAN CO.	*18*	*(0.4%)*	37	(0.3%)	**55**	*2*	*(0.9%)*	22	(0.4%)	*16*	*(0.4%)*	15	(0.3%)	**31**
DOUGLAS CO.	*2*	*(0.0%)*	2	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*2*	*(0.1%)*	0	(0.0%)	**2**
FRANKLIN CO.	*20*	*(0.5%)*	48	(0.4%)	**68**	*1*	*(0.5%)*	14	(0.2%)	*19*	*(0.5%)*	34	(0.7%)	**53**
GRANT CO.	*10*	*(0.2%)*	30	(0.3%)	**40**	*1*	*(0.5%)*	19	(0.3%)	*9*	*(0.2%)*	11	(0.2%)	**20**
KITTITAS CO.	*3*	*(0.1%)*	17	(0.2%)	**20**	*0*	*(0.0%)*	9	(0.1%)	*3*	*(0.1%)*	8	(0.2%)	**11**
KLICKITAT CO.	*4*	*(0.1%)*	9	(0.1%)	**13**	*0*	*(0.0%)*	6	(0.1%)	*4*	*(0.1%)*	3	(0.1%)	**7**
YAKIMA CO.	*56*	*(1.3%)*	162	(1.4%)	**218**	*4*	*(1.8%)*	76	(1.2%)	*52*	*(1.3%)*	86	(1.7%)	**138**
REGION 3	*327*	*(7.8%)*	919	(8.1%)	**1,246**	*24*	*(11.0%)*	464	(7.5%)	*303*	*(7.6%)*	455	(8.9%)	**758**
ISLAND CO.	*15*	*(0.4%)*	58	(0.5%)	**73**	*1*	*(0.5%)*	33	(0.5%)	*14*	*(0.4%)*	25	(0.5%)	**39**
SAN JUAN CO.	*6*	*(0.1%)*	18	(0.2%)	**24**	*1*	*(0.5%)*	10	(0.2%)	*5*	*(0.1%)*	8	(0.2%)	**13**
SKAGIT CO.	*26*	*(0.6%)*	58	(0.5%)	**84**	*4*	*(1.8%)*	33	(0.5%)	*22*	*(0.6%)*	25	(0.5%)	**47**
SNOHOMISH CO.	*229*	*(5.4%)*	636	(5.6%)	**865**	*15*	*(6.8%)*	309	(5.0%)	*214*	*(5.4%)*	327	(6.4%)	**541**
WHATCOM CO.	*51*	*(1.2%)*	149	(1.3%)	**200**	*3*	*(1.4%)*	79	(1.3%)	*48*	*(1.2%)*	70	(1.4%)	**118**
REGION 5	*470*	*(11.2%)*	1,193	(10.6%)	**1,663**	*30*	*(13.7%)*	663	(10.7%)	*440*	*(11.0%)*	530	(10.4%)	**970**
KITSAP CO.	*77*	*(1.8%)*	205	(1.8%)	**282**	*2*	*(0.9%)*	115	(1.9%)	*75*	*(1.9%)*	90	(1.8%)	**165**
PIERCE CO.	*393*	*(9.3%)*	988	(8.7%)	**1,381**	*28*	*(12.8%)*	548	(8.8%)	*365*	*(9.1%)*	440	(8.7%)	**805**
REGION 6	*339*	*(8.1%)*	938	(8.3%)	**1,277**	*14*	*(6.4%)*	475	(7.7%)	*325*	*(8.1%)*	463	(9.1%)	**788**
CLALLAM CO.	*21*	*(0.5%)*	53	(0.5%)	**74**	*2*	*(0.9%)*	29	(0.5%)	*19*	*(0.5%)*	24	(0.5%)	**43**
CLARK CO.	*152*	*(3.6%)*	408	(3.6%)	**560**	*3*	*(1.4%)*	210	(3.4%)	*149*	*(3.7%)*	198	(3.9%)	**347**
COWLITZ CO.	*35*	*(0.8%)*	90	(0.8%)	**125**	*1*	*(0.5%)*	51	(0.8%)	*34*	*(0.9%)*	39	(0.8%)	**73**
GRAYS HARBOR CO.	*17*	*(0.4%)*	54	(0.5%)	**71**	*1*	*(0.5%)*	32	(0.5%)	*16*	*(0.4%)*	22	(0.4%)	**38**
JEFFERSON CO.	*9*	*(0.2%)*	23	(0.2%)	**32**	*3*	*(1.4%)*	15	(0.2%)	*6*	*(0.2%)*	8	(0.2%)	**14**
LEWIS CO.	*8*	*(0.2%)*	40	(0.4%)	**48**	*1*	*(0.5%)*	25	(0.4%)	*7*	*(0.2%)*	15	(0.3%)	**22**
MASON CO.	*22*	*(0.5%)*	75	(0.7%)	**97**	*0*	*(0.0%)*	23	(0.4%)	*22*	*(0.6%)*	52	(1.0%)	**74**
PACIFIC CO.	*9*	*(0.2%)*	16	(0.1%)	**25**	*1*	*(0.5%)*	10	(0.2%)	*8*	*(0.2%)*	6	(0.1%)	**14**
SKAMANIA CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	5	(0.1%)	*0*	*(0.0%)*	2	(0.0%)	**2**
THURSTON CO.	*65*	*(1.5%)*	170	(1.5%)	**235**	*2*	*(0.9%)*	75	(1.2%)	*63*	*(1.6%)*	95	(1.9%)	**158**
WAHKIAKUM CO.	*1*	*(0.0%)*	2	(0.0%)	**3**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	2	(0.0%)	**3**
SUBTOTAL	*1,452*	*(34.5%)*	4,063	(36.0%)	**5,515**	*91*	*(41.6%)*	2,127	(34.3%)	*1,361*	*(34.1%)*	1,936	(38.1%)	**3,297**
REGION 4 (KING CO)	*2,758*	*(65.5%)*	7,229	(64.0%)	**9,987**	*128*	*(58.4%)*	4,079	(65.7%)	*2,630*	*(65.9%)*	3,150	(61.9%)	**5,780**
STATE TOTAL	*4,210*	*(100%)*	11,292	(100%)	**15,502**	*219*	*(100%)*	6,206	(100%)	*3,991*	*(100%)*	5,086	(100%)	**9,077**

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

8. County of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing..

TABLE 6. WASHINGTON STATE HIV[1] CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 12/31/2005

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2001		2002		2003		2004[5]		2005 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	379	(92%)	1,135	(85%)	2,095	(85%)	3,609	(86%)	270	(87%)	263	(85%)	276	(85%)	284	(85%)	299	(86%)
Female	33	(8%)	205	(15%)	363	(15%)	601	(14%)	42	(13%)	46	(15%)	48	(15%)	49	(15%)	50	(14%)
Total	412	(100%)	1,340	(100%)	2,458	(100%	4,210	(100%	312	(100%	309	(100%	324	(100%)	333	(100%)	349	(100%
Race/Ethnicity[10]																		
White, not Hispanic	352	(85%)	1,034	(77%)	1,633	(66%)	3,019	(72%)	215	(69%)	199	(64%)	215	(66%)	205	(62%)	221	(63%)
Black, not Hispanic	39	(9%)	159	(12%)	426	(17%)	624	(15%)	46	(15%)	67	(22%)	61	(19%)	66	(20%)	59	(17%)
Hispanic (All Races)	10	(2%)	92	(7%)	238	(10%)	340	(8%)	31	(10%)	24	(8%)	29	(9%)	32	(10%)	43	(12%)
Asian/Pacific Islander	0	(0%)	1	(0%)	5	(0%)	6	(0%)	1	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Asian	3	(1%)	25	(2%)	72	(3%)	100	(2%)	10	(3%)	7	(2%)	9	(3%)	12	(4%)	10	(3%)
Hawaiian/Pacific Islander	1	(0%)	0	(0%)	6	(0%)	7	(0%)	0	(0%)	0	(0%)	2	(1%)	0	(0%)	2	(1%)
Native American/Alaskan	5	(1%)	18	(1%)	39	(2%)	62	(1%)	5	(2%)	6	(2%)	6	(2%)	9	(3%)	4	(1%)
Multi-race	0	(0%)	2	(0%)	15	(1%)	17	(0%)	1	(0%)	4	(1%)	1	(0%)	6	(2%)	3	(1%)
Unknown	2	(0%)	9	(1%)	24	(1%)	35	(1%)	3	(1%)	2	(1%)	1	(0%)	3	(1%)	7	(2%)
Total	412	(100%)	1,340	(100%)	2,458	(100%	4,210	(100%	312	(100%	309	(100%	324	(100%)	333	(100%)	349	(100%
Exposure Category																		
Male/male sex (MSM)	279	(68%)	826	(62%)	1,516	(62%)	2,621	(62%)	191	(61%)	196	(63%)	206	(64%)	199	(60%)	193	(55%)
Injecting Drug Use (IDU)	44	(11%)	136	(10%)	204	(8%)	384	(9%)	25	(8%)	26	(8%)	24	(7%)	28	(8%)	23	(7%)
MSM and IDU	50	(12%)	115	(9%)	189	(8%)	354	(8%)	23	(7%)	26	(8%)	23	(7%)	25	(8%)	36	(10%)
Transfusion/Transplant	3	(1%)	6	(0%)	11	(0%)	20	(0%)	2	(1%)	1	(0%)	0	(0%)	2	(1%)	4	(1%)
Hemophilia	9	(2%)	4	(0%)	1	(0%)	14	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Heterosexual Contact[6]	11	(3%)	129	(10%)	271	(11%)	411	(10%)	38	(12%)	40	(13%)	36	(11%)	34	(10%)	35	(10%)
Mother at Risk for HIV	3	(1%)	25	(2%)	7	(0%)	35	(1%)	0	(0%)	0	(0%)	1	(0%)	1	(0%)	0	(0%)
No Identified Risk[7]/Other	13	(3%)	99	(7%)	259	(11%)	371	(9%)	33	(11%)	20	(6%)	34	(10%)	44	(13%)	58	(17%)
Total	412	(100%)	1,340	(100%)	2,458	(100%	4,210	(100%	312	(100%	309	(100%	324	(100%)	333	(100%)	349	(100%
AIDSNET Region																		
Region 1	21	(5%)	55	(4%)	100	(4%)	176	(4%)	14	(4%)	16	(5%)	14	(4%)	18	(5%)	12	(3%)
Region 2	11	(3%)	41	(3%)	88	(4%)	140	(3%)	9	(3%)	14	(5%)	7	(2%)	9	(3%)	18	(5%)
Region 3	31	(8%)	121	(9%)	175	(7%)	327	(8%)	21	(7%)	15	(5%)	26	(8%)	23	(7%)	33	(9%)
Region 5	39	(9%)	166	(12%)	265	(11%)	470	(11%)	27	(9%)	37	(12%)	40	(12%)	24	(7%)	41	(12%)
Region 6	28	(7%)	110	(8%)	201	(8%)	339	(8%)	30	(10%)	23	(7%)	28	(9%)	31	(9%)	38	(11%)
Subtotal	130	(32%)	493	(37%)	829	(34%)	1,452	(34%)	101	(32%)	105	(34%)	115	(35%)	105	(32%)	142	(41%)
Region 4 (King Co.)	282	(68%)	847	(63%)	1,629	(66%)	2,758	(66%)	211	(68%)	204	(66%)	209	(65%)	228	(68%)	207	(59%)
Total	412	(100%)	1,340	(100%)	2,458	(100%	4,210	(100%	312	(100%	309	(100%	324	(100%)	333	(100%)	349	(100%

1 This includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. It does not include those who have only been tested anonymously for HIV.

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 7. WASHINGTON STATE AIDS CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 12/31/2005

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2001		2002		2003		2004[5]		2005 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	1,889	(97%)	5,696	(92%)	2,695	(86%)	10,280	(91%)	340	(87%)	342	(83%)	354	(84%)	332	(83%)	309	(85%)
Female	62	(3%)	493	(8%)	457	(14%)	1,012	(9%)	49	(13%)	71	(17%)	67	(16%)	68	(17%)	54	(15%)
Total	1,951	(100%)	6,189	(100%)	3,152	(100%)	11,292	(100%)	389	(100%)	413	(100%)	421	(100%)	400	(100%)	363	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	1,710	(88%)	4,919	(79%)	2,080	(66%)	8,709	(77%)	250	(64%)	265	(64%)	271	(64%)	265	(66%)	225	(62%)
Black, not Hispanic	130	(7%)	606	(10%)	529	(17%)	1,265	(11%)	74	(19%)	74	(18%)	67	(16%)	65	(16%)	65	(18%)
Hispanic (All Races)	75	(4%)	417	(7%)	349	(11%)	841	(7%)	45	(12%)	43	(10%)	54	(13%)	42	(11%)	42	(12%)
Asian/Pacific Islander	3	(0%)	31	(1%)	11	(0%)	45	(0%)	3	(1%)	3	(1%)	1	(0%)	0	(0%)	1	(0%)
Asian	11	(1%)	68	(1%)	66	(2%)	145	(1%)	4	(1%)	13	(3%)	10	(2%)	9	(2%)	16	(4%)
Hawaiian/Pacific Islander	5	(0%)	9	(0%)	14	(0%)	28	(0%)	1	(0%)	2	(0%)	5	(1%)	2	(1%)	1	(0%)
Native American/Alaskan	16	(1%)	117	(2%)	76	(2%)	209	(2%)	10	(3%)	11	(3%)	10	(2%)	10	(3%)	9	(2%)
Multi-race	1	(0%)	20	(0%)	16	(1%)	37	(0%)	0	(0%)	1	(0%)	3	(1%)	5	(1%)	3	(1%)
Unknown	0	(0%)	2	(0%)	11	(0%)	13	(0%)	2	(1%)	1	(0%)	0	(0%)	2	(1%)	1	(0%)
Total	1,951	(100%)	6,189	(100%)	3,152	(100%)	11,292	(100%)	389	(100%)	413	(100%)	421	(100%)	400	(100%)	363	(100%)
Exposure Category																		
Male/male sex (MSM)	1,499	(77%)	4,227	(68%)	1,744	(55%)	7,470	(66%)	229	(59%)	220	(53%)	238	(57%)	209	(52%)	189	(52%)
Injecting Drug Use (IDU)	82	(4%)	573	(9%)	375	(12%)	1,030	(9%)	41	(11%)	47	(11%)	46	(11%)	44	(11%)	42	(12%)
MSM and IDU	234	(12%)	612	(10%)	270	(9%)	1,116	(10%)	32	(8%)	36	(9%)	33	(8%)	32	(8%)	34	(9%)
Transfusion/Transplant	47	(2%)	64	(1%)	14	(0%)	125	(1%)	0	(0%)	1	(0%)	1	(0%)	3	(1%)	2	(1%)
Hemophilia	30	(2%)	52	(1%)	9	(0%)	91	(1%)	1	(0%)	0	(0%)	1	(0%)	1	(0%)	1	(0%)
Heterosexual Contact[6]	29	(1%)	372	(6%)	395	(13%)	796	(7%)	51	(13%)	71	(17%)	55	(13%)	55	(14%)	51	(14%)
Mother at Risk for HIV	8	(0%)	18	(0%)	2	(0%)	28	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
No Identified Risk[7]/Other	22	(1%)	271	(4%)	343	(11%)	636	(6%)	35	(9%)	38	(9%)	47	(11%)	56	(14%)	44	(12%)
Total	1,951	(100%)	6,189	(100%)	3,152	(100%)	11,292	(100%)	389	(100%)	413	(100%)	421	(100%)	400	(100%)	363	(100%)
AIDSNET Region																		
Region 1	79	(4%)	343	(6%)	208	(7%)	630	(6%)	20	(5%)	26	(6%)	27	(6%)	30	(8%)	24	(7%)
Region 2	48	(2%)	191	(3%)	144	(5%)	383	(3%)	17	(4%)	15	(4%)	20	(5%)	23	(6%)	19	(5%)
Region 3	111	(6%)	514	(8%)	294	(9%)	919	(8%)	30	(8%)	40	(10%)	38	(9%)	40	(10%)	51	(14%)
Region 5	171	(9%)	645	(10%)	377	(12%)	1,193	(11%)	57	(15%)	37	(9%)	38	(9%)	45	(11%)	38	(10%)
Region 6	108	(6%)	531	(9%)	299	(9%)	938	(8%)	48	(12%)	48	(12%)	27	(6%)	41	(10%)	41	(11%)
Subtotal	517	(26%)	2,224	(36%)	1,322	(42%)	4,063	(36%)	172	(44%)	166	(40%)	150	(36%)	179	(45%)	173	(48%)
Region 4 (King Co.)	1,434	(74%)	3,965	(64%)	1,830	(58%)	7,229	(64%)	217	(56%)	247	(60%)	271	(64%)	221	(55%)	190	(52%)
Total	1,951	(100%)	6,189	(100%)	3,152	(100%)	11,292	(100%)	389	(100%)	413	(100%)	421	(100%)	400	(100%)	363	(100%)

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

WASHINGTON STATE REPORTED CASES OF CHLAMYDIA, GONORRHEA, EARLY SYPHILIS, JANUARY - DECEMBER 2005

	Chlamydia		Gonorrhea		Early Syphilis	
Sex	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Male	5,142	(27.6)	2,114	(56.6)	207	(95.8)
Female	13,465	(72.4)	1,620	(43.4)	9	(4.2)
TOTAL	**18,607**	**(100.0)**	**3,734**	**(100.0)**	**216**	**(100.0)**
Age						
0-14	232	(1.2)	34	(0.9)	0	(0.0)
15-19	5,833	(31.3)	704	(18.9)	5	(2.3)
20-24	7,024	(37.7)	1,047	(28.0)	29	(13.4)
25-29	2,898	(15.6)	625	(16.7)	24	(11.1)
30-34	1,176	(6.3)	409	(11.0)	26	(12.0)
35-39	604	(3.2)	340	(9.1)	56	(25.9)
40+	588	(3.2)	546	(14.6)	76	(35.2)
Unknown	252	(1.4)	29	(0.8)	0	(0.0)
TOTAL	**18,607**	**(100.0)**	**3,734**	**(100.0)**	**216**	**(100.0)**
Ethnic/Race						
White	8,224	(44.2)	1,552	(41.6)	159	(73.6)
Black	2,201	(11.8)	902	(24.2)	12	(5.6)
Hispanic	2,640	(14.2)	290	(7.8)	24	(11.1)
Native Hawaiian/Other Pacific Islander	188	(1.0)	17	(0.5)	2	(0.9)
Asian	657	(3.5)	74	(2.0)	9	(4.2)
Native American	551	(3.0)	90	(2.4)	1	(0.5)
Multi	497	(2.7)	74	(2.0)	3	(1.4)
Other	157	(0.8)	27	(0.7)	1	(0.5)
Unknown	3,492	(18.8)	708	(19.0)	5	(2.3)
TOTAL	**18,607**	**(100.0)**	**3,734**	**(100.0)**	**216**	**(100.0)**
Provider Type	**Cases**	**# Prov**	**Cases**	**# Prov**	**Cases**	**# Prov**
Community Health Ctr.	466	32	114	21	11	4
Emergency Care (Not Hosp.)	363	60	127	39	5	4
Family Planning	4,119	55	316	38	1	1
Health Plan/HMO's	828	43	137	30	8	4
Hospitals	1,650	92	613	71	13	10
Indian Health	214	22	49	10	0	0
Jail/Correction/Detention	839	42	258	33	6	3
Migrant Health	457	20	52	13	2	2
Military	744	11	104	5	3	1
Neighborhood Health	159	14	35	9	0	0
OB/GYN	1,305	124	103	56	1	1
Other	3,738	623	683	252	55	26
Private Physician	512	231	101	62	27	5
Reproductive Health	1,311	17	180	13	2	2
STD	1,243	37	780	21	81	4
Student Health	659	27	82	15	1	1
TOTAL	**18,607**	**1,450**	**3,734**	**688**	**216**	**68**

WASHINGTON STATE REPORTED STDs BY COUNTY JANUARY - JUNE 2005

	CT	GC	HERPES	P & S	EL	L/LL	CONG	TOTAL
Adams	32	5	2	0	0	0	-	0
Asotin	37	1	18	0	0	0	-	0
Benton	406	20	38	1	0	1	-	2
Chelan	174	6	23	0	0	0	-	0
Clallam	145	21	29	0	0	0	-	0
Clark	916	205	72	5	0	6	-	11
Columbia	4	2	2	0	0	0	-	0
Cowlitz	322	104	30	1	0	0	-	1
Douglas	72	2	15	1	0	0	-	1
Ferry	16	0	0	0	0	0	-	0
Franklin	221	17	15	1	0	1	-	2
Garfield	1	1	0	0	0	0	-	0
Grant	188	13	22	0	0	0	-	0
Grays Harbor	164	5	11	0	0	1	-	1
Island	183	31	34	4	0	1	-	5
Jefferson	57	2	14	1	0	0	-	1
King	5,602	1,786	798	119	57	71	-	247
Kitsap	660	77	67	4	1	3	-	8
Kittitas	154	9	18	0	0	0	-	0
Klickitat	26	4	0	0	0	0	-	0
Lewis	162	12	25	1	0	0	-	1
Lincoln	5	0	2	0	0	0	-	0
Mason	162	13	20	0	1	9	-	10
Okanogan	124	1	13	0	0	0	-	0
Pacific	33	3	2	0	0	0	-	0
Pend Oreille	10	2	4	0	0	0	-	0
Pierce	3,422	674	231	3	2	17	-	22
San Juan	10	0	2	1	0	0	-	1
Skagit	294	32	65	1	0	4	-	5
Skamania	9	3	0	0	0	0	-	0
Snohomish	1,555	244	305	3	2	11	-	16
Spokane	1,071	121	155	0	0	8	-	8
Stevens	72	4	5	0	0	0	-	0
Thurston	528	56	82	2	0	2	-	4
Wahkiakum	5	0	0	0	0	0	-	0
Walla Walla	160	1	22	0	0	1	-	1
Whatcom	480	117	77	1	0	4	-	5
Whitman	152	2	14	1	0	0	-	1
Yakima	973	138	99	2	1	3	-	6
YEAR TO DATE	18,607	3,734	2,331	152	64	143	0	359
PRV YR TO DATE	17,633	2,810	2,153	150	51	135	0	336
% CHANGE	5.5%	32.9%	8.3%	1.3%	25.5%	5.9%	NC	6.8%

CT = Chlamydia Trachomatis
GC = Gonorrhea
HERPES = Initial Genital Herpes
P/S = Primary & Secondary Syphilis
EL = Early Latent Syphilis
L/LL = Late/Late Latent Syphilis
CONG = Congenital Syphilis

MONTHLY TUBERCULOSIS CASE TOTALS BY COUNTY, 2004-2005

	JAN		FEB		MARCH		APRIL		MAY		JUNE		JULY		AUG		SEP		OCT		NOV		DEC		TOTAL	
COUNTY	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
Adams																									0	0
Asotin																									0	0
Benton			1						2										1						4	0
Chelan								1																	0	1
Clallam																									0	0
Clark		1		2	1	2			1		2					2			1	2	1		2		8	9
Columbia										1															0	1
Cowlitz																		1							0	1
Douglas																		1							0	1
Ferry																									0	0
Franklin			1						1			1		1	1										3	2
Garfield																									0	0
Grant								1								1						1			0	3
Grays Harbor						1								1						1				1	1	3
Island									1				1			1	2				1				5	1
Jefferson																						1			0	1
King	8	7	12	5	7	15	15	9	6	6	19	14	18	7	4	13	11	9	9	5	7	11	17	26	133	127
Kitsap				1				2		1			1			1							1	2	6
Kittitas							1																		1	0
Klickitat																									0	0
Lewis			1																						1	0
Lincoln																									0	0
Mason																							1		1	0
Okanogan																									0	0
Pacific																									0	0
Pend-Oreille																									0	0
Pierce	1	1	2	4	1		2	2	1	2	9	2	1	5	4	2	2	4	1	4	3	1	7		34	27
San Juan																	1								1	0
Skagit						1				1	1			3		1			1					1	2	7
Skamania																1									0	1
Snohomish		1		1		2			1		2	1	1	10	2	2	2	1	5	2	2	4			15	24
Spokane	3		1		1	4						1	1					1		2		3	1	1	7	12
Stevens																		1							0	1
Thurston		2	1						1	1	1						1	1	3			1		1	7	6
Wahkiakum																									0	0
Walla Walla						1										1			1						1	2
Whatcom	1	1		1	1		1	1			1			1					2			1			6	5
Whitman						1																			0	1
Yakima	2	1	3	1			1	2	1	1		2	1	4			2		1			3	1		12	14
State Total	15	14	22	15	11	27	20	18	15	13	35	21	24	32	11	25	21	19	25	16	14	26	31	30	244	256
YTD State Total		14	37	29	48	56	68	74	83	87	118	108	142	140	153	165	174	184	199	200	213	226	244	256	244	256

Note: Detailed analysis of tuberculosis morbidity is contained in "Washington State Tuberculosis Epidemiological Profile - 2002" and is available to order from the State TB Program by calling (360) 236-3443.

Deadline Details For *Washington State Responds* Quarterly Newsletter

The deadline for the next issue of ***Washington State Responds*** is **March 20, 2006**. The calendar start date for the issue is **May 5, 2006**. To submit information, corrections, or to be added or dropped from the mailing list, contact Barbara Schuler, Washington State Department of Health, HIV Prevention and Education Services, P.O. Box 47840, Olympia, WA 98504-7840. You may also telephone her at: (360) 236-3487 or call the Washington State Hotline at **1-800-272-2437, ext. 0** to leave a message**.** You may fax your information to (360) 236-3400, or preferably send via e-mail to: barbara.schuler@ doh.wa.gov

We greatly appreciate news of your work or your organization!

Thank you for taking the time and effort to write, call, fax or e-mail!

DOH HIV/AIDS PREVENTION AND EDUCATION SERVICES

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This newsletter may contain HIV prevention messages that may not be appropriate for all audiences. Since HIV infection is spread primarily through sexual practices or by sharing syringe needles, prevention messages and programs may address these topics. If you are not seeking such information or are offended by such materials, do not visit this site.